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.

GENERAL DEPARTMENTAL PROCEDURES

TITLE I

CHAPTER 1
DEPARTMENT ORGANIZATION AND GENERAL DEFINITIONS

1.1(217) History and mission
1.2(217) Definitions
1.3(217) Department structure
1.4(217) Information
1.5(217) Health and human services council
1.6(217) State council on developmental disabilities

CHAPTERS 2 to 7
Reserved

CHAPTER 8
PAYMENT OF SMALL CLAIMS

8.1(217) Authorization to reimburse

CHAPTERS 9 and 10
Reserved

CHAPTER 11
COLLECTION OF DEBT

11.1(217) Definitions
11.2(217) Establishment of claim
11.3(217) Application of payment
11.4(217) Setoff against state income tax refund, rebate, or other state payments, including, for example, state employee wages
11.5(234) Setoff against federal income tax refund or other federal payments, including, for example, federal employee wages

CHAPTER 12
Reserved

CHAPTER 13
PROGRAM EVALUATION

13.1(234,239B,249A,514I) Definitions
13.2(234,239B,249A,514I) Review of public assistance records by the department
13.3(234,239B,249A,514I) Cases to be reviewed
13.4(234,239B,249A,514I) Notification of review
13.5(234,239B,249A,514I) Review procedure
13.6(234) Failure to cooperate
13.7(234,239B,249A,514I) Report of findings
13.8(234,237A,239B,249A,514I) Federal review

CHAPTERS 14 and 15
Reserved

CHAPTER 16
NOTICES

16.1(17A) Definitions
16.2(17A) Notices

TITLE II

CHAPTERS 17 to 21

Reserved

TITLE III

MENTAL HEALTH

CHAPTER 22
AUTISM SUPPORT PROGRAM

22.1(225D) Definitions
22.2(225D) Eligibility and application requirements
22.3(225D) Cost-sharing requirements and graduated schedule of cost sharing
22.4(225D) Review of financial eligibility, cost-sharing requirements, exemption from cost sharing, and disenrollment in the program
22.5(225D) Initial-service authorization and renewal-of-service authorization
22.6(225D) Provider network
22.7(225D) Financial management of the program
22.8(225D) Appeal

CHAPTER 23

Reserved

CHAPTER 24
ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS, INTELLECTUAL DISABILITIES, OR DEVELOPMENTAL DISABILITIES

DIVISION I

SERVICES FOR INDIVIDUALS WITH DISABILITIES

24.1(225C) Definitions
24.2(225C) Standards for policy and procedures
24.3(225C) Standards for organizational activities
24.4(225C) Standards for services
24.5(225C) Accreditation
24.6(225C) Deemed status (all services)
24.7(225C) Complaint process (all services)
24.8(225C) Appeal procedure
24.9(225C) Exceptions to policy
24.10 to 24.19 Reserved

DIVISION II

CRISIS RESPONSE SERVICES

24.20(225C) Definitions
24.21(225C) Standards for crisis response services
24.22(225C) Standards for policies and procedures
24.23(225C) Standards for organizational activities
24.24(225C) Standards for crisis response staff
24.25(225C) Standards for services
24.26(225C) Accreditation
24.27(225C) Deemed status
24.28(225C) Complaint process
24.29(225C) Appeal procedure
24.30(225C) Exceptions to policy
24.31(225C) Standards for individual crisis response services
24.32(225C) Crisis evaluation
24.33(225C) Twenty-four-hour crisis response
24.34(225C) Twenty-four-hour crisis line
24.35(225C) Warm line
24.36(225C) Mobile response
24.37(225C) Twenty-three-hour crisis observation and holding
24.38(225C) Crisis stabilization community-based services (CSCBS)

24.39(225C) Crisis stabilization residential services (CSRS)
24.40(225C) Medication—administration, storage and documentation
24.41 to 24.49 Reserved

DIVISION III
COMMUNITY MENTAL HEALTH CENTERS

24.50(230A) Definitions
24.51(230A) Community mental health center designation
24.52(230A) Standards for policies and procedures
24.53(230A) Standards for organizational activities
24.54(230A) Standards for core services and supports
24.55(230A) Accreditation of community mental health centers

CHAPTERS 25 to 27
Reserved

CHAPTER 28
POLICIES FOR MENTAL HEALTH
INSTITUTES AND RESOURCE CENTER

28.1(218) Definitions
28.2(222,230) Payor of last resort
28.3(229) Grievances
28.4(217,218) Photographing and recording of individuals and use of cameras
28.5(217,218) Interviews and statements
28.6(218) Use of grounds, facilities, or equipment
28.7(218) Tours of facility
28.8(218) Donations
28.9(217) Release of confidential information

CHAPTER 29
MENTAL HEALTH INSTITUTES

29.1(218,229) Voluntary admissions
29.2(229) Authorization for treatment
29.3(217,228,229) Rights of individuals
29.4(218) Visiting

CHAPTER 30
STATE RESOURCE CENTER

30.1(218,222) Admission
30.2(222) Liability for support
30.3(217,218) Rights of individuals
30.4(218) Visiting

CHAPTER 31
CIVIL COMMITMENT UNIT FOR SEXUAL OFFENDERS

31.1(229A) Definitions
31.2(229A) Visitation
31.3(229A) Grievances
31.4(229A) Photographing and recording patients
31.5(229A) Public media
31.6(229A) Communication with patients
31.7(229A) Building and grounds
31.8(229A) Cost of care

CHAPTERS 32 to 35
Reserved

CHAPTER 36
FACILITY ASSESSMENTS

36.1(249A) Intermediate care facilities for persons with an intellectual disability assessment

36.2(249A) Determination and payment of fee
36.3(249L) Nursing facility assessment
36.4(249L) Determination and payment of assessment
36.5(249M) Participating hospital assessment
36.6(249M) Determination and payment of assessment

CHAPTER 37
Reserved

CHAPTER 38
DEVELOPMENTAL DISABILITIES BASIC STATE GRANT

38.1(217,42USC144) Administering agency
38.2(217,42USC144) Definitions
38.3(217,42USC144) Program eligibility
38.4(217,42USC144) Conflict of interest policy

CHAPTER 39
Reserved

TITLE IV
FAMILY INVESTMENT PROGRAM

CHAPTER 40
APPLICATION FOR AID

40.1 to 40.20 Reserved
40.21(239B) Definitions
40.22(239B) Application
40.23(239B) Date of application
40.24(239B) Procedure with application
40.25(239B) Time limit for decision
40.26(239B) Effective date of grant
40.27(239B) Continuing eligibility
40.28(239B) Referral for investigation
40.29(239B) Alternate payees

CHAPTER 41
GRANTING ASSISTANCE

41.1 to 41.20 Reserved
41.21(239B) Eligibility factors specific to child
41.22(239B) Eligibility factors specific to payee
41.23(239B) Home, residence, citizenship, and alienage
41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program
41.25(239B) Uncategorized factors of eligibility
41.26(239B) Resources
41.27(239B) Income
41.28(239B) Need standards
41.29(239B) Composite FIP/SSI cases
41.30(239B) Time limits

CHAPTERS 42 to 44
Reserved

CHAPTER 45
PAYMENT

45.1 to 45.20 Reserved
45.21(239B) Issuing payment
45.22(239B) Return
45.23(239B) Held warrants
45.24(239B) Underpayment

45.25(239B) Deceased payees
45.26(239B) Limitation on payment
45.27(239B) Rounding of need standard and payment amount

CHAPTER 46
OVERPAYMENT RECOVERY

46.1 to 46.20 Reserved
46.21(239B) Definitions
46.22(239B) Monetary standards
46.23(239B) Notification and appeals
46.24(239B) Determination of overpayments
46.25(239B) Source of recoupment
46.26 Reserved
46.27(239B) Procedures for recoupment
46.28 Reserved
46.29(239B) Fraudulent misrepresentation of residence

CHAPTER 47
DIVERSION INITIATIVES

47.1 to 47.20 Reserved
47.21(239B) Definitions
47.22(239B) Availability of the family self-sufficiency grants program
47.23(239B) General criteria
47.24(239B) Assistance available in family self-sufficiency grants
47.25(239B) Application, notification, and appeals
47.26(239B) Approved local plans for family self-sufficiency grants
47.27(239B) Evaluation of family self-sufficiency grants
47.28(239B) Recovery of FSSG overpayments

CHAPTER 48
PROMOTING AWARENESS OF THE BENEFITS OF A HEALTHY MARRIAGE

48.1(234) Definitions
48.2(234) Eligibility criteria
48.3(234) Notice and eligibility period

CHAPTER 49
FAMILY DEVELOPMENT AND SELF-SUFFICIENCY (FaDSS) PROGRAM

49.1(216A) Definitions
49.2(216A) Identification of conditions and criteria for families at risk
49.3(216A) Referral of families
49.4(216A) Funding of grants
49.5(216A) Grants not renewed and grants terminated or reduced
49.6(216A) Appeal
49.7(216A) Contract with grantee
49.8(216A) Grantee responsibilities
49.9(216A) Evaluation

TITLE V
STATE SUPPLEMENTARY ASSISTANCE

CHAPTER 50
APPLICATION FOR ASSISTANCE

50.1(249) Definitions
50.2(249) Application procedures
50.3(249) Approval of application and effective date of eligibility
50.4(249) Reviews
50.5(249) Application under conditional benefits

CHAPTER 51
ELIGIBILITY

51.1(249) Definitions
51.2(249) Application for other benefits
51.3(249) Supplementation
51.4(249) Eligibility for residential care
51.5(249) Dependent relatives
51.6(249) Residence
51.7(249) Eligibility for supplement for Medicare and Medicaid eligibles
51.8(249) Income from providing room and board
51.9(249) Furnishing of social security number
51.10(249) Recovery

CHAPTER 52
PAYMENT
52.1(249) Assistance standards

CHAPTER 53
Reserved

CHAPTER 54
FACILITY PARTICIPATION
54.1(249) Application and contract agreement
54.2(249) Maintenance of case records
54.3(249) Payments for residential care facilities
54.4(249) Goods and services provided
54.5(249) Personal needs account
54.6(249) Case activity report
54.7(249) Billing procedures

TITLE VI
GENERAL PUBLIC ASSISTANCE PROVISIONS

CHAPTERS 55 and 56
Reserved

CHAPTER 57
INTERIM ASSISTANCE REIMBURSEMENT
57.1(249) Definitions
57.2(249) Requirements for reimbursement
57.3(249) Certificate of authority

CHAPTER 58
COMMUNITY SERVICES BLOCK GRANT (CSBG)
58.1(216A,PL97-35) Definitions
58.2(216A,PL97-35) Purposes
58.3(216A,PL97-35) Uses of funds
58.4(216A,PL97-35) Apportionment distribution
58.5(216A,PL97-35) Eligibility requirements
58.6(216A,PL97-35) Community action plan
58.7(216A,PL97-35) Review and acceptance of community action plans
58.8(216A,PL97-35) Ineligible items
58.9(216A) Audits and records
58.10(216A,PL97-35) Designating eligible entities for unserved areas
58.11(216A,PL97-35) Termination and reduction of funding
58.12(216A,PL97-35) Client grievance and appeal process
58.13(216A,PL97-35) Further criteria

CHAPTER 59
LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)
59.1(216A,PL97-35,PL98-558) Definitions
59.2(216A,PL97-35,PL98-558) Household eligibility

59.3(216A,PL97-35,PL98-558)	LAAs
59.4(216A,PL97-35,PL98-558)	Application period
59.5(216A,PL97-35,PL98-558)	Payments
59.6(216A,PL97-35,PL98-558)	Change in status
59.7(216A,PL97-35,PL98-558)	Vendor agreement
59.8(216A,PL97-35,PL98-558)	Crisis assistance
59.9(216A,PL97-35,PL98-558)	Assurance 16 activities
59.10(216A,PL97-35,PL98-558)	Grievances and appeals
59.11(216A,PL97-35,PL98-558)	Further criteria

CHAPTER 60
REFUGEE CASH ASSISTANCE

60.1(217)	Alienage requirements
60.2(217)	Application procedures
60.3(217)	Effective date of grant
60.4(217)	Accepting other assistance
60.5(217)	Eligibility factors
60.6(217)	Students in institutions of higher education
60.7(217)	Time limit for eligibility
60.8(217)	Criteria for exemption from registration for employment services, registration, and refusal to register
60.9(217)	Work and training requirements
60.10(217)	Uncategorized factors of eligibility
60.11(217)	Temporary absence from home
60.12(217)	Application
60.13(217)	Continuing eligibility
60.14(217)	Alternate payees
60.15(217)	Payment
60.16(217)	Overpayment recovery

CHAPTER 61
REFUGEE SERVICES PROGRAM

61.1(217)	Definitions
61.2(217)	Authority
61.3(217)	Eligibility
61.4(217)	Planning and coordinating the placement of refugees
61.5(217)	Services of the department available for refugees
61.6(217)	Provision of services
61.7(217)	Application for services
61.8(217)	Adverse service actions
61.9(217)	Client appeals
61.10(217)	Refugee resettlement moneys
61.11(217)	Unaccompanied refugee minors program
61.12(217)	Targeted assistance grants

CHAPTER 62
RENT REIMBURSEMENT

62.1(425)	Eligible claimants
62.2(425)	Dual claims
62.3(425)	Multipurpose building
62.4(425)	Income
62.5(425)	Simultaneous homesteads
62.6(425)	Mobile, modular, and manufactured homes
62.7(425)	Totally disabled
62.8(425)	Household
62.9(425)	Homestead
62.10(425)	Gross rent/rent constituting property taxes paid
62.11(425)	Leased land
62.12(425)	Property: taxable status

62.13(425) Income: spouse
62.14(425) Common law marriage
62.15(425) Audit of claim
62.16(425) Extension of time for filing a claim
62.17(425) Proration of claims
62.18(425) Unreasonable hardship
62.19(425) Appeal

CHAPTER 63
WEATHERIZATION

63.1(216A,PL94-385,PL98-558) Eligible households
63.2(216A,PL94-385,PL98-558) Local administering agencies (LAAs)
63.3(216A,PL94-385,PL98-558) Application period
63.4(216A,PL94-385,PL98-558) Payments
63.5(216A,PL94-385,PL98-558) Grievances and appeals
63.6(216A,PL94-385,PL98-558) Further criteria

CHAPTER 64
INDIVIDUAL DEVELOPMENT ACCOUNT (IDA)

64.1(541A) Definitions
64.2(541A) Establishment of individual development accounts
64.3(541A) Eligibility, state match payments, and state tax provisions
64.4(541A) Requests for proposals—operation of IDAs
64.5(541A) Authorized withdrawals of principal and income
64.6(541A) Notice of nonapproved withdrawals and closure of the account
64.7(541A) Transfers of assets of an IDA

TITLE VII
FOOD PROGRAMS

CHAPTER 65
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM ADMINISTRATION

65.1(234) Definitions
65.2(234) Administration of program
65.3(234) State options
65.4(234) Treatment centers and group living arrangements
65.5(234) Appeals
65.6(234) Proration of benefits
65.7(234) Notice of expiration issuance
65.8(234) Verification
65.9(234) Prospective budgeting
65.10(234) Effective date of change
65.11(234) Work requirements
65.12(234) Income
65.13(234) Deductions
65.14(234) Student resources
65.15(234) Reinstatement

CHAPTER 66
EMERGENCY FOOD ASSISTANCE PROGRAM

66.1(234) Definitions
66.2(234) Household eligibility

CHAPTER 67
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM
FOR WOMEN, INFANTS, AND CHILDREN (WIC)

67.1(135) Definitions
67.2(135) Administration of program
67.3(135) Certification of participants

67.4(135) Food delivery
67.5(135) Education
67.6(135) Right to appeal—participant
67.7(135) Right to appeal—local agencies
67.8(135) Right to appeal—vendor
67.9(135) State monitoring of contract agencies
67.10(135) Civil rights
67.11(135) WIC program violation

CHAPTERS 68 to 72
Reserved

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 73
MANAGED CARE

73.1(249A) Definitions
73.2(249A) Contracts with a managed care plan (MCP)
73.3(249A) Enrollment
73.4(249A) Disenrollment process
73.5(249A) MCP covered services
73.6(249A) Amount, duration and scope of services
73.7(249A) Emergency services
73.8(249A) Access to service
73.9(249A) Incident reporting
73.10(249A) Discharge planning
73.11(249A) Level of care (LOC) assessment
73.12(249A) Appeal of MCP actions
73.13(249A) Appeal to department
73.14(249A) Continuation of benefits
73.15(249A) Grievances
73.16(249A) Written record
73.17(249A) Information concerning procedures relating to the review of MCP decisions and actions
73.18(249A) Records and reports
73.19(249A) Audits
73.20(249A) Marketing
73.21(249A) Enrollee education
73.22(249A) Payment to the MCP
73.23(249A) Claims payment by the MCP
73.24(249A) Quality assurance
73.25(249A) Certifications and program integrity

CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

74.1(249A,249N) Definitions
74.2(249A,249N) Eligibility factors
74.3(249A,249N) Application
74.4(249A,249N) Financial eligibility
74.5(249A,249N) Enrollment period
74.6(249A,249N) Reporting changes
74.7(249A,249N) Reenrollment
74.8(249A,249N) Terminating enrollment
74.9(249A,249N) Recovery
74.10(249A,249N) Right to appeal
74.11(249A) Financial participation
74.12(249A) Benefits and service delivery
74.13(249A,249N) Claims and reimbursement methodologies
74.14(249A,249N) Discontinuance of program

CHAPTER 75
CONDITIONS OF ELIGIBILITY

DIVISION I
DEFINITIONS, COVERAGE GROUPS, AND GENERAL CONDITIONS OF ELIGIBILITY

75.1(249A) Definitions
75.2(249A) Categories of persons covered
75.3(249A) Family-related Medicaid
75.4(249A) Persons who have been screened and found to need breast or cervical cancer treatment (BCCT)
75.5(249A) Persons under age 65; refugees
75.6(249A) Aged, blind or disabled
75.7(249A) Presumptive eligibility
75.8(249A) Medically needy persons
75.9(249A) Furnishing of social security number
75.10(249A) Residency requirements
75.11(249A) Citizenship or alienage requirements
75.12(249A) Inmates of public institutions
75.13 Reserved
75.14(249A) Establishing liability and obtaining support
75.15(249A) Medical resources
75.16(249A) Medical assistance lien
75.17 Reserved
75.18(249A) Continuous eligibility for pregnant women
75.19(249A) Continuous eligibility for children
75.20(249A) Medical assistance corrective payments
75.21(249A) Health insurance premium payment (HIPP) program
75.22(249A) AIDS/HIV health insurance premium payment program
75.23(249A) Disposal of assets for less than fair market value after August 10, 1993
75.24(249A) Treatment of trusts established after August 10, 1993
75.25(249A) Treatment of Medicaid qualifying trusts
75.26(249A) Conservatorships
75.27(249A) AIDS/HIV settlement payments
75.28(249A) Recovery
75.29(249A) Investigation of eligibility
75.30 to 75.49 Reserved

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO FAMILY-RELATED COVERAGE GROUPS

75.50(249A) Eligibility factors specific to child
75.51(249A) Eligibility factors specific to parents and caretakers
75.52(249A) The effect of age on eligibility
75.53(249A) Absence from the home
75.54(249A) Pending SSI approval
75.55(249A) Resources not considered
75.56(249A) Income eligibility
75.57 to 75.69 Reserved

DIVISION III
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

75.70(249A) Financial eligibility based on MAGI
75.71(249A) Coverage groups subject to MAGI methodology
75.72(249A) MAGI household composition
75.73(249A) Income under MAGI methodology
75.74(249A) Income limits
75.75 to 75.79 Reserved

DIVISION IV
ELIGIBILITY FACTORS SPECIFIC TO NON-MAGI-RELATED COVERAGE GROUPS, PERSONS IN MEDICAL INSTITUTIONS AND PERSONS RECEIVING LONG-TERM CARE SERVICES

75.80(249A) Categorical relatedness to supplemental security income (SSI)
75.81(249A) Disability requirements for non-MAGI-related Medicaid

75.82(249A) Determination of countable income and resources for persons in a medical institution
75.83(249A) Client participation in payment for medical institution care
75.84(249A) Entrance fee for continuing care retirement community or life care community
75.85(249A) Disqualification for long-term care assistance due to substantial home equity

CHAPTER 76
ENROLLMENT AND REENROLLMENT

76.1(249A) Definitions
76.2(249A) Application for medical assistance
76.3(249A) Referrals from the FFM
76.4(249A) Express lane eligibility
76.5(249A) Enrollment through SSI
76.6(249A) Referral for Medicare savings program
76.7(249A) Presumptive eligibility
76.8(249A) Applicant and member responsibilities
76.9(249A) Responsible persons and authorized representatives
76.10(249A) Right to withdraw the application
76.11(249A) Choice of electronic notifications
76.12(249A) Application not required
76.13(249A) Initial enrollment
76.14(249A) Reenrollment
76.15(249A) Report of changes
76.16(249A) Action on information received
76.17(249A) Timeliness requirements for conducting automatic redeterminations of eligibility

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

77.1(249A) Physicians
77.2(249A) Retail pharmacies
77.3(249A) Pharmacists
77.4(249A) Hospitals
77.5(249A) Dentists
77.6(249A) Podiatrists
77.7(249A) Optometrists
77.8(249A) Opticians
77.9(249A) Chiropractors
77.10(249A) Home health agencies
77.11(249A) Medical equipment and appliances, prosthetic devices and medical supplies
77.12(249A) Ambulance service
77.13(249A) Behavioral health intervention
77.14(249A) Hearing aid dispensers
77.15(249A) Audiologists
77.16(249A) Community mental health centers
77.17(249A) Screening centers
77.18(249A) Physical therapists
77.19(249A) Orthopedic shoe dealers and repair shops
77.20(249A) Rehabilitation agencies
77.21(249A) Independent laboratories
77.22(249A) Rural health clinics
77.23(249A) Psychologists
77.24(249A) Maternal health centers
77.25(249A) Ambulatory surgical centers
77.26(249A) Federally qualified health centers
77.27(249A) Advanced registered nurse practitioners
77.28(249A) Speech-language pathologists
77.29(249A) Physician associates
77.30(249A) HCBS habilitation services

77.31(249A) Behavioral health services
77.32(249A) Birth centers
77.33(249A) Area education agencies
77.34(249A) Case management provider organizations
77.35(249A) HCBS health and disability waiver service providers
77.36(249A) Occupational therapists
77.37(249A) Hospice providers
77.38(249A) HCBS elderly waiver service providers
77.39(249A) HCBS AIDS/HIV waiver service providers
77.40(249A) HCBS intellectual disability waiver service providers
77.41(249A) Assertive community treatment
77.42(249A) HCBS brain injury (BI) waiver service providers
77.43(249A) HCBS physical disability waiver service providers
77.44(249A) Public health agencies
77.45(249A) Infant and toddler program providers
77.46(249A) Local education agency (LEA) services providers
77.47(249A) Indian health facilities
77.48(249A) HCBS children's mental health waiver service providers
77.49(249A) Ordering and referring providers
77.50(249A) Child care medical services
77.51(249A) Community-based neurobehavioral rehabilitation services
77.52(249A) Qualified Medicare beneficiary (QMB) providers
77.53(249A) Health insurance premium payment (HIPP) providers
77.54(249A) Crisis response services
77.55(249A) Subacute mental health services

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL SERVICES

78.1(249A) Physicians' services
78.2(249A) Prescribed outpatient drugs
78.3(249A) Inpatient hospital services
78.4(249A) Dental services
78.5(249A) Podiatrists
78.6(249A) Optometrists
78.7(249A) Opticians
78.8(249A) Chiropractors
78.9(249A) Home health agencies
78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies
78.11(249A) Ambulance service
78.12(249A) Behavioral health intervention
78.13(249A) Nonemergency medical transportation
78.14(249A) Hearing aids
78.15(249A) Orthopedic shoes
78.16(249A) Community mental health centers
78.17(249A) Physical therapists
78.18(249A) Screening centers
78.19(249A) Rehabilitation agencies
78.20(249A) Independent laboratories
78.21(249A) Rural health clinics
78.22(249A) Family planning clinics
78.23(249A) Other clinic services
78.24(249A) Psychologists
78.25(249A) Maternal health centers
78.26(249A) Ambulatory surgical center services
78.27(249A) Home- and community-based habilitation services
78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review
78.29(249A) Behavioral health services

78.30(249A) Birth centers
78.31(249A) Hospital outpatient services
78.32(249A) Area education agencies
78.33(249A) Case management services
78.34(249A) HCBS health and disability waiver services
78.35(249A) Occupational therapist services
78.36(249A) Hospice services
78.37(249A) HCBS elderly waiver services
78.38(249A) HCBS AIDS/HIV waiver services
78.39(249A) Federally qualified health centers
78.40(249A) ARNPs
78.41(249A) HCBS intellectual disability waiver services
78.42(249A) Pharmacists providing covered vaccines
78.43(249A) HCBS brain injury waiver services
78.44(249A) Lead inspection services
78.45(249A) Assertive community treatment
78.46(249A) Physical disability waiver service
78.47(249A) Pharmaceutical case management services
78.48(249A) Public health agencies
78.49(249A) Infant and toddler program services
78.50(249A) Local education agency services
78.51(249A) Indian health service 638 facility services
78.52(249A) HCBS children's mental health waiver services
78.53(249A) Speech-language pathology services
78.54(249A) Services rendered via telehealth
78.55(249A) Community-based neurobehavioral rehabilitation services
78.56(249A) Child care medical services
78.57(249A) Qualified Medicare beneficiary (QMB) provider services
78.58(249A) Health insurance premium payment (HIPP) provider services
78.59(249A) Crisis response services
78.60(249A) Subacute mental health services

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

79.1(249A) Principles governing reimbursement of providers of medical and health services
79.2(249A) Sanctions
79.3(249A) Maintenance of records by providers of service
79.4(249A) Reviews and audits
79.5(249A) Nondiscrimination on the basis of handicap
79.6(249A) Provider participation agreement
79.7(249A) Medicaid advisory council
79.8(249A) Beneficiary advisory council
79.9(249A) Requests for prior authorization
79.10(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services
79.11(249A) Requests for preadmission review
79.12(249A) Requests for preprocedure surgical review
79.13(249A) Advance directives
79.14(249A) Requirements for enrolled Medicaid providers supplying laboratory services
79.15(249A) Provider enrollment
79.16(249A) Education about false claims recovery
79.17(249A) Requirements for prescribing controlled substances

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT

80.1(249A) Submission of claims
80.2(249A) Payment from other sources
80.3(249A) Time limit for submission of claims and claim adjustments
80.4(249A) Authorization process
80.5(249A) Payment to provider—exception

80.6(249A) Health care data match program

CHAPTER 81
NURSING FACILITIES

81.1(249A) Definitions
81.2(249A) Initial approval for nursing facility care
81.3(249A) Arrangements with residents
81.4(249A) Discharge and transfer
81.5(249A) Financial and statistical report and determination of payment rate
81.6(249A) Continued review
81.7(249A) Records
81.8(249A) Payment procedures
81.9(249A) Billing procedures
81.10(249A) Closing of facility
81.11(249A) Conditions of participation for nursing facilities
81.12(249A) Audits
81.13(249A) Nurse aide requirements and training and testing programs
81.14(249A) Sanctions
81.15(249A) Out-of-state facilities
81.16(249A) Outpatient services
81.17(249A) Rates for Medicaid eligibles
81.18(249A) State-funded personal needs supplement
81.19(249A) Enforcement of compliance
81.20(249A) Appeal of a determination of noncompliance
81.21(249A) Civil money penalties—when penalty is collected
81.22(249A) Civil money penalties—settlement authority
81.23(249A) Civil money penalties—deduction of penalty from amount owed
81.24(249A) Use of penalties collected by the department

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR PERSONS
WITH AN INTELLECTUAL DISABILITY

82.1(249A) Definitions
82.2(249A) Licensing and certification
82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability
82.4(249A) Financial and statistical report
82.5(249A) Eligibility for services
82.6(249A) Initial approval for ICF/ID care
82.7(249A) Determination of need for continued stay
82.8(249A) Arrangements with residents
82.9(249A) Discharge and transfer
82.10(249A) Records
82.11(249A) Payment procedures
82.12(249A) Billing procedures
82.13(249A) Closing of facility
82.14(249A) Audits
82.15(249A) Out-of-state facilities
82.16(249A) State-funded personal needs supplement

CHAPTER 83
MEDICAID WAIVER SERVICES
DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

83.1(249A) Definitions
83.2(249A) Eligibility
83.3(249A) Application
83.4(249A) Financial participation
83.5(249A) Redetermination
83.6(249A) Allowable services

83.7(249A)	Service plan
83.8(249A)	Adverse service actions
83.9(249A)	Appeal rights
83.10 to 83.20	Reserved
	DIVISION II—HCBS ELDERLY WAIVER SERVICES
83.21(249A)	Definitions
83.22(249A)	Eligibility
83.23(249A)	Application
83.24(249A)	Client participation
83.25(249A)	Redetermination
83.26(249A)	Allowable services
83.27(249A)	Service plan
83.28(249A)	Adverse service actions
83.29(249A)	Appeal rights
83.30(249A)	Enhanced services
83.31 to 83.40	Reserved
	DIVISION III—HCBS AIDS/HIV WAIVER SERVICES
83.41(249A)	Definitions
83.42(249A)	Eligibility
83.43(249A)	Application
83.44(249A)	Financial participation
83.45(249A)	Redetermination
83.46(249A)	Allowable services
83.47(249A)	Service plan
83.48(249A)	Adverse service actions
83.49(249A)	Appeal rights
83.50 to 83.59	Reserved
	DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES
83.60(249A)	Definitions
83.61(249A)	Eligibility
83.62(249A)	Application
83.63(249A)	Client participation
83.64(249A)	Redetermination
83.65	Reserved
83.66(249A)	Allowable services
83.67(249A)	Service plan
83.68(249A)	Adverse service actions
83.69(249A)	Appeal rights
83.70(249A)	Rent subsidy program
83.71 to 83.80	Reserved
	DIVISION V—BRAIN INJURY WAIVER SERVICES
83.81(249A)	Definitions
83.82(249A)	Eligibility
83.83(249A)	Application
83.84(249A)	Client participation
83.85(249A)	Redetermination
83.86(249A)	Allowable services
83.87(249A)	Service plan
83.88(249A)	Adverse service actions
83.89(249A)	Appeal rights
83.90 to 83.100	Reserved
	DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES
83.101(249A)	Definitions
83.102(249A)	Eligibility
83.103(249A)	Application
83.104(249A)	Client participation
83.105(249A)	Redetermination
83.106(249A)	Allowable services
83.107(249A)	Individual service plan

83.108(249A) Adverse service actions
83.109(249A) Appeal rights
83.110 to 83.120 Reserved
DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES
83.121(249A) Definitions
83.122(249A) Eligibility
83.123(249A) Application
83.124(249A) Financial participation
83.125(249A) Redetermination
83.126(249A) Allowable services
83.127(249A) Service plan
83.128(249A) Adverse service actions
83.129(249A) Appeal rights

CHAPTER 84
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
84.1(249A) Definitions
84.2(249A) Eligibility
84.3(249A) Screening services
84.4(249A) Referral
84.5(249A) Follow up

CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS
85.1(249A) Acute care in psychiatric hospitals
85.2(249A) Out-of-state placement
85.3(249A) Eligibility of persons under the age of 21
85.4(249A) Eligibility of persons aged 65 and over
85.5(249A) Client participation
85.6(249A) Responsibilities of hospitals
85.7(249A) Psychiatric hospital reimbursement
85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64
85.9(249A) Psychiatric medical institutions for children—conditions for participation
85.10(249A) Eligibility of persons under the age of 21
85.11(249A) Client participation
85.12(249A) Responsibilities of facilities
85.13(249A) Outpatient day treatment for persons aged 20 or under
85.14(249A) Conditions of participation
85.15(249A) Out-of-state placement
85.16(249A) Eligibility of persons aged 65 and over
85.17(249A) Client participation
85.18(249A) Responsibilities of nursing facility
85.19(249A) Policies governing reimbursement
85.20(249A) State-funded personal needs supplement

CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWKI) PROGRAM
86.1(514I) Definitions
86.2(514I) Eligibility factors
86.3(514I) Application process
86.4(514I) Coordination with Medicaid
86.5(514I) Effective date of coverage
86.6(514I) Selection of a plan
86.7(514I) Cancellation
86.8(514I) Premiums and copayments
86.9(514I) Annual reviews of eligibility
86.10(514I) Reporting changes
86.11(514I) Notice requirements
86.12(514I) Appeals and fair hearings

86.13(514I) Covered services
86.14(514I) Participating health and dental plans
86.15(514I) Use of donations to the hawki program
86.16(514I) Recovery
86.17(514I) Supplemental dental-only coverage

CHAPTER 87
FAMILY PLANNING PROGRAM

87.1(217) Definitions
87.2(217) Eligibility
87.3(217) Enrollment
87.4(217) Effective date of eligibility
87.5(217) Period of eligibility
87.6(217) Reporting changes
87.7(217) Funding of family planning services program
87.8(217) Availability of services
87.9(217) Payment of covered services
87.10(217) Submission of claims
87.11(217) Providers eligible to participate

CHAPTER 88
SPECIALIZED MANAGED CARE PROGRAMS

88.1(249A) Definitions
88.2(249A) Process for new and expanding PACE organization service areas
88.3(249A) Three-way agreement with Medicare and Medicaid
88.4(249A) Center administration
88.5(249A) Safety
88.6(249A) Physical environment
88.7(249A) Program services
88.8(249A) Patient education
88.9(249A) Grievances and appeals
88.10(249A) Participant enrollment and disenrollment
88.11(249A) Records and reports
88.12(249A) Health Insurance Portability and Accountability Act of 1996 (HIPAA)
88.13(249A) Funding
88.14(249A) Federal and state monitoring; sanctions

CHAPTER 89
DEBTS DUE FROM TRANSFERS OF ASSETS

89.1(249F) Definitions
89.2(249F) Creation of debt
89.3(249F) Exceptions
89.4(249F) Presumption of intent
89.5(249F) Notice of debt
89.6(249F) No timely request of a hearing
89.7(249F) Timely request for a hearing
89.8(249F) Department-requested hearing
89.9(249F) Filing and docketing of the order
89.10(249F) Exemption from Iowa Code chapter 17A

CHAPTER 90
FEE-FOR-SERVICE CASE MANAGEMENT

90.1(249A) Definitions
90.2(249A) Targeted case management
90.3(249A) Termination of TCM services
90.4(249A) Case management services
90.5(249A) Rights restrictions
90.6(249A) Documentation and billing
90.7(249A) Case management services provider requirements

CHAPTER 91
MEDICARE DRUG SUBSIDY

91.1(249A) Definitions
91.2(249A) Application
91.3(249A) Eligibility determination
91.4(249A) Effective date
91.5(249A) Changes in circumstances
91.6(249A) Reinvestigation
91.7(249A) Appeals

CHAPTER 92
Reserved

TITLE IX
WORK INCENTIVE DEMONSTRATION

CHAPTER 93
PROMISE JOBS PROGRAM

93.1(239B) Definitions
93.2(239B) Program administration
93.3(239B) Registration and referral
93.4(239B) FIA
93.5(239B) Assessment
93.6(239B) Job readiness and job search activities
93.7(239B) Work activities
93.8(239B) Education and training activities
93.9(239B) Other FIA activities
93.10(239B) Required documentation and verification
93.11(239B) Supportive payments
93.12(239B) Recovery of PROMISE JOBS expense payments
93.13(239B) Resolution of participation issues
93.14(239B) Problems that may provide good cause for participation issues
93.15(239B) Right of appeal
93.16(239B) Resolution of an LBP
93.17(239B) Worker displacement grievance procedure

TITLE X
SUPPORT RECOVERY

CHAPTER 94
CHILD SUPPORT PROMOTING OPPORTUNITIES FOR PARENTS PROGRAM

94.1(252B) Definitions
94.2(252B) Purpose and incentives
94.3(252B) Establishment of designated providers
94.4(252B) Selection of designated providers
94.5(252B) Termination of designated providers
94.6(252B) Reports and records
94.7(252B) Receipt of incentives
94.8(17A) Right of appeal

CHAPTER 95
CHILD SUPPORT SERVICES

95.1(252B) Definitions
95.2(252B) Child support eligibility and services
95.3(252B) Crediting of current and delinquent support
95.4(252B) Prepayment of support
95.5(252B) Lump sum settlement
95.6(17A) Appeals
95.7(252B) Termination of services
95.8(252B) Child support services attorney

95.9(252B) Effective date of support
95.10(252B) Continued services available to canceled FIP or Medicaid recipients
95.11(252B) Cooperation of public assistance recipients in establishing and obtaining support
95.12(252B) Cooperation of public assistance applicants in establishing and obtaining support
95.13(252B) Cooperation in establishing and obtaining support in nonpublic assistance cases
95.14(252B) Charging pass-through fees
95.15(252B) Reimbursing assistance with collections of assigned support
95.16(252B) Child support account
95.17(252B) Emancipation verification
95.18(17A) Right of appeal
95.19(17A) Appeal record

CHAPTER 96
INFORMATION AND RECORDS

96.1(252B) Access to information and records from other sources
96.2(252B) Refusal to comply with written request or subpoena
96.3(252B) Procedure for refusal
96.4(252B) Conference conducted
96.5(252B) Fine assessed
96.6(252B) Objection to fine or failure to pay
96.7(17A) Right of appeal

CHAPTER 97
COLLECTION SERVICES CENTER

97.1(252B) Definitions
97.2(252B) Transfer of records and payments
97.3(252B) Support payment records
97.4(252B) Method of payment
97.5(252D) Electronic transmission of payments
97.6(252B) Authorization of payment
97.7(252B) Processing misdirected payments
97.8(17A) Right of appeal

CHAPTER 98
SUPPORT ENFORCEMENT SERVICES

98.1(252E) Definitions
98.2(252E) Medical support health benefit plan information
98.3(252E) Medical support insurer authorization
98.4(252E) Medical support enforcement
98.5(252E) Contesting enforcement of medical support
98.6(252D) Income withholding of delinquent support
98.7(252D) Income withholding amounts
98.8(252D) Amendment of amount of withholding due to hardship
98.9(252D) Immediate income withholding
98.10(252D) Approval of request for immediate income withholding
98.11(252D) Immediate income withholding amounts
98.12(252D) Immediate income withholding amounts when current support has ended
98.13(252D,252E) Income withholding for medical support
98.14(252D,252E) Maximum amounts to be withheld for income withholding
98.15(252D) Income withholding for multiple obligations
98.16(252D) Income withholding notice to employer and obligor
98.17(252D) Contesting the income withholding
98.18(252D) Termination of income withholding
98.19(252D) Modification of income withholding
98.20(252D) Refunds of amounts improperly withheld
98.21(96) Child support intercept of unemployment insurance benefits
98.22(252B) Administrative seek employment order
98.23(252B) Effective date of seek employment order
98.24(252B) Method and requirements of reporting for administrative seek employment order

98.25(252B) Reasons for noncompliance of administrative seek employment
98.26(252B) Administrative seek employment method of service
98.27(252B) Administrative seek employment order duration of order
98.28(252B) Setoff against payment owed to a person by a state agency
98.29(252B) Setoff against state income tax refund or rebate
98.30(252B) Offset against federal income tax refund and federal nontax payment
98.31(252I) Administrative levy
98.32(252J) Referral for license sanction
98.33(252J) Reasons for exemption from license sanction
98.34(252J) Notice of potential sanction of license
98.35(252J) License sanction conference
98.36(252J) License Sanction Payment Agreement
98.37(252J) Staying the process of license sanction due to full payment of support
98.38(252J) Duration of license sanction
98.39(252B) Procedures for providing information to consumer reporting agencies
98.40(252B) Difficult-to-collect arrearages
98.41(252B) Enforcement services by private attorney entitled to state compensation
98.42(17A) Right of appeal
98.43(17A) Appeal record

CHAPTER 99
CHILD SUPPORT GUIDELINES

99.1(234,252B,252H) Income considered
99.2(234,252B) Allowable deductions
99.3(234,252B) Determining net income
99.4(234,252B) Applying the guidelines
99.5(234,252B) Deviation from guidelines
99.6(17A) Right of appeal

CHAPTER 100
ESTABLISHMENT OF PATERNITY AND SUPPORT

100.1(598,600B) Definitions
100.2(252A) Temporary support
100.3(252F) When paternity may be established administratively
100.4(252F) Mother's certified statement
100.5(252F) Notice of alleged paternity and support debt
100.6(252F) Conference to discuss paternity and support issues
100.7(252F) Amount of support obligation
100.8(252F) Paternity contested
100.9(252F) Paternity test results challenge
100.10(252F) Agreement to entry of paternity and support order
100.11(252F) Entry of order establishing paternity only
100.12(252F) Exception to time limit
100.13(252F) Genetic test costs assessed
100.14(598,600B) Communication between parents
100.15(598,600B) Continuation of enforcement
100.16(598,600B) Satisfaction of accrued support
100.17(252C) Establishment of an administrative order
100.18(17A) Right of appeal

CHAPTER 101
ADJUSTMENT AND MODIFICATION OF SUPPORT

101.1(252B,252H) Definitions
101.2(252H) Confidentiality of financial information
101.3(252H) Payment of fees
101.4(252B,252H) Review of permanent child support obligations
101.5(252B,252H) Notice requirements—review and adjustment
101.6(252B,252H) Financial information—review and adjustment
101.7(252B,252H) Review and adjustment of a child support obligation

101.8(252B,252H) Medical support—review and adjustment
101.9(252B,252H) Denying requests—review and adjustment
101.10(252B,252H) Withdrawing requests — review and adjustment
101.11(252H) Effective date of review and adjustment
101.12(252H) Availability of service—administrative modification
101.13(252H) Modification of child support obligations
101.14(252H) Notice requirements—administrative modification
101.15(252H) Financial information—administrative modification
101.16(252H) Challenges to the proposed modification action
101.17(252H) Misrepresentation of fact—administrative modification
101.18(252H) Effective date of modification
101.19(252H) Denying requests—administrative modification
101.20(252H) Withdrawing requests—administrative modification
101.21(252B,252H) Child care add-on
101.22(17A) Right of appeal

CHAPTER 102
SUSPENSION AND REINSTATEMENT OF SUPPORT

102.1(252B) Definitions
102.2(252B) Availability of service—suspension by mutual consent
102.3(252B) Basis for suspension of support by mutual consent
102.4(252B) Request for assistance to suspend by mutual consent
102.5(252B) Order suspending support by mutual consent
102.6(252B) Suspension of enforcement of current support—suspension by mutual consent
102.7(252B) Availability of service—suspension by payor's request
102.8(252B) Basis for suspension of support by payor's request
102.9(252B) Request for assistance to suspend by payor's request
102.10(252B) Determining eligibility for suspension by payor's request
102.11(252B) Order suspending support by payor's request
102.12(252B) Suspension of enforcement of current support—suspension by payor's request
102.13(252B) Request for reinstatement
102.14(252B) Reinstatement
102.15(252B) Reinstatement of enforcement of support
102.16(252B) Temporary suspension becomes final
102.17(17A) Right of appeal

CHILDREN'S INSTITUTIONS

TITLE XI

CHAPTER 103
STATE TRAINING SCHOOL

103.1(218) Definitions
103.2(218) Admission
103.3(218) Plan of care
103.4(218) Communication with students
103.5(218) Photographing and recording of students
103.6(218) Employment of students
103.7(218) Temporary home visits
103.8(218) Grievances
103.9(692A) Sex offender registration
103.10(218) Alleged child abuse
103.11(233A) Cost of care
103.12(218) Buildings and grounds
103.13(68B,218) Gifts and bequests

CHAPTER 104
Reserved

TITLE XII
LICENSING AND APPROVED STANDARDS

CHAPTER 105
JUVENILE DETENTION AND SHELTER CARE HOMES

105.1(232) Definitions
105.2(232) Buildings and grounds
105.3(232) Personnel policies
105.4 Reserved
105.5(232) Staff
105.6(232) Intake procedures
105.7(232) Assessments
105.8(232) Program services
105.9(232) Medication management and administration
105.10(232) Control room—juvenile detention home only
105.11(232) Clothing
105.12(232) Staffings
105.13(232) Child abuse
105.14(232) Daily log
105.15(232) Children's rights
105.16(232) Discipline
105.17(232) Case files
105.18(232) Discharge
105.19(232) Approval
105.20(232) Provisional approval
105.21(232) Mechanical restraint—juvenile detention only
105.22(232) Chemical restraint
105.23(232) Mandatory reporting of child abuse and training

CHAPTER 106
CERTIFICATION STANDARDS FOR CHILDREN'S RESIDENTIAL FACILITIES

106.1(237C) Definitions
106.2(237C) Application of the standards
106.3(237C) Application for a certificate of approval
106.4(237C) Certificate of approval
106.5(237C) Denial, suspension, or revocation
106.6(237C) Providing for basic needs
106.7(237C) Educational programs and services
106.8(237C) Protection from mistreatment, physical abuse, sexual abuse, and neglect
106.9(237C) Discipline
106.10(237C) Record checks
106.11(237C) Seclusion and restraints
106.12(237C) Health
106.13(237C) Safety
106.14(237C) Emergencies
106.15(237C) Buildings and physical premises
106.16(237C) Sanitation, water, and waste disposal
106.17(237C) Staffing
106.18(237C) Reports and inspections
106.19(232) Mandatory reporting of child abuse

CHAPTER 107
CERTIFICATION OF ADOPTION INVESTIGATORS

107.1(600,234) Definitions
107.2(600,234) Application
107.3(600,234) Requirements for certification
107.4(600,234) Granting, denial, or revocation of certification
107.5(600,234) Certificate
107.6(600,234) Renewal of certification
107.7(600,234) Investigative services

107.8(600,234) International adoptions postplacement report
107.9(600,234) Retention of adoption records
107.10(600,234) Reporting of violations
107.11(600,234) Appeals

CHAPTER 108
LICENSING AND REGULATION OF CHILD-PLACING AGENCIES

108.1(238) Definitions
108.2(238) Licensing procedure
108.3(238) Administration and organization
108.4(238) Staff qualifications
108.5(238) Staffing requirements
108.6(238) Personnel administration
108.7(238) Foster care services
108.8(238) Foster home studies
108.9(238) Adoption services
108.10(238) Supervised apartment living placement services

CHAPTER 109
CHILD CARE CENTERS

109.1(237A) Definitions
109.2(237A) Licensure procedures
109.3(237A) Inspection and evaluation
109.4(237A) Administration
109.5(237A) Parental participation
109.6(237A) Personnel
109.7(237A) Professional growth and development
109.8(237A) Staff ratio requirements
109.9(237A) Records
109.10(237A) Health and safety policies
109.11(237A) Physical facilities
109.12(237A) Activity program requirements
109.13(237A) Food services
109.14(237A) Extended evening care
109.15(237A) School-based before- and after-school and summer programs
109.16(237A) Get-well center

CHAPTER 110
CHILD DEVELOPMENT HOMES AND CHILD CARE HOMES WITH A CHILD CARE ASSISTANCE PROVIDER AGREEMENT

110.1(237A) Definitions
110.2(237A) Application for registration as a child development home or payment as a nonregistered child care home
110.3(237A) Renewal of registration or payment application
110.4(237A) Compliance checks
110.5(237A) Parental access
110.6(237A) Number of children
110.7(237A) Provider requirements
110.8(237A) Standards
110.9(237A) Files
110.10(237A) Professional development
110.11(237A) Child development home registration; child care assistance provider agreement and payment application for nonregistered providers
110.12(237A) Complaints
110.13(237A) Additional requirements for child development home category A
110.14(237A) Additional requirements for child development home category B
110.15(237A) Additional requirements for child development home category C without a co-provider
110.16(237A) Additional requirements for child development home category C with co-provider
110.17(237A) Relative care exemptions

110.18(237A) Registration actions for nonpayment of child support
110.19(237A) Prohibition from involvement with child care

CHAPTER 111
FAMILY-LIFE HOMES

111.1(249) Definitions
111.2(249) Application for certification
111.3(249) Provisions pertaining to the certificate
111.4(249) Physical standards
111.5(249) Personal characteristics of family-life home family
111.6(249) Health of family
111.7(249) Planned activities and personal effects
111.8(249) Client eligibility
111.9(249) Medical examinations, records, and care of a client
111.10(249) Placement agreement
111.11(249) Legal liabilities
111.12(249) Emergency care and release of client
111.13(249) Information about client to be confidential

CHAPTER 112
LICENSING AND REGULATION OF CHILD FOSTER CARE FACILITIES

112.1(237) Applicability
112.2(237) Definitions
112.3(237) Application for license
112.4(237) License
112.5(237) Denial
112.6(237) Revocation
112.7(237) Provisional license
112.8(237) Adverse actions
112.9(237) Suspension
112.10(232) Mandatory reporting of child abuse and training
112.11(237) Required training on the reasonable and prudent parent standard
112.12(237) Record checks

CHAPTER 113
LICENSING AND REGULATION OF FOSTER FAMILY HOMES

113.1(237) Applicability
113.2(237) Definitions
113.3(237) Licensing procedure
113.4(237) Provisions pertaining to the license
113.5(237) Physical standards
113.6(237) Sanitation, water, and waste disposal
113.7(237) Safety
113.8(237) Foster parent training
113.9(237) Involvement of kin
113.10(237) Information on the child(ren) placed in the home
113.11(237) Health of foster family
113.12(237) Characteristics of foster parents
113.13(237) Record checks
113.14(237) Reference checks
113.15(237) Unannounced visits
113.16(237) Planned activities and personal effects
113.17(237) Medical examinations and health care of the child(ren)
113.18(237) Training and discipline of child(ren)
113.19(237) Emergency care and release of child(ren)
113.20(237) Changes in foster family home

CHAPTER 114
LICENSING AND REGULATION OF ALL GROUP LIVING FOSTER CARE FACILITIES FOR CHILDREN

114.1(237) Applicability
114.2(237) Definitions
114.3(237) Physical standards
114.4(237) Sanitation, water, and waste disposal
114.5(237) Safety
114.6(237) Organization and administration
114.7(237) Policies and record-keeping requirements
114.8(237) Staff
114.9(237) Intake procedures
114.10(237) Program services
114.11(237) Case files
114.12(237) Drug utilization and control
114.13(237) Children's rights
114.14(237) Personal possessions
114.15(237) Religion—culture
114.16(237) Work or vocational experiences
114.17(237) Family involvement
114.18(237) Children's money
114.19(237) Child abuse
114.20(237) Discipline
114.21(237) Illness, accident, death, or unauthorized absence from the facility
114.22(237) Records
114.23(237) Unannounced visits
114.24(237) Record check information
114.25(237) Standards for private juvenile shelter care and detention homes

CHAPTER 115
LICENSING AND REGULATION OF COMPREHENSIVE RESIDENTIAL FACILITIES FOR CHILDREN

115.1(237) Applicability
115.2(237) Definitions
115.3(237) Information upon admission
115.4(237) Staff
115.5(237) Casework services
115.6(237) Restraints
115.7(237) Control room
115.8(237) Locked cottages
115.9(237) Mechanical restraint
115.10(237) Restraint and control room use debriefing
115.11(237) Chemical restraint

CHAPTER 116
LICENSING AND REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN WITH AN INTELLECTUAL DISABILITY OR BRAIN INJURY

116.1(237) Definitions
116.2(237) Qualifications of staff
116.3(237) Staff-to-client ratio
116.4(237) Program components
116.5(237) Restraint

CHAPTER 117
FOSTER PARENT TRAINING

117.1(237) Required preservice training
117.2(237) Required orientation
117.3(237) Application materials for in-service training

117.4(237) Application process for in-service training
117.5(237) Application decisions
117.6(237) Application conference available
117.7(237) Required in-service training
117.8(237) Specific in-service training required
117.9(237) Foster parent training expenses

CHAPTER 118
CHILD CARE QUALITY RATING SYSTEM

DIVISION I
QUALITY RATING SYSTEM (QRS)

118.1(237A) Definitions
118.2(237A) Application for quality rating
118.3(237A) Rating standards for child care centers and preschools (sunsetting on July 31, 2011)
118.4(237A) Rating criteria for child development homes (sunsetting on July 31, 2011)
118.5(237A) Rating standards for child care centers, preschools, and programs operating under the authority of an accredited school district or nonpublic school
118.6(237A) Rating criteria for child development homes
118.7(237A) Award of quality rating
118.8(237A) Adverse actions

DIVISION II
IOWA QUALITY FOR KIDS (IQ4K)

118.9(237A) Definitions
118.10(237A) Application for Iowa quality for kids (IQ4K) rating
118.11(237A) Application effective date
118.12(237A) Approved program's expiration date
118.13(237A) Renewal application submission, Levels 1-4
118.14(237A) Renewal application submission, Level 5
118.15(237A) Increased rating
118.16(237A) Change in location of facility
118.17(237A) Ongoing eligibility
118.18(237A) Monitoring
118.19(237A) Professional development training
118.20(237A) Rating standards for a child care center, a preschool, or a program operating under the authority of an accredited school district or nonpublic school
118.21(237A) Criteria for IQ4K—Level 1 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school
118.22(237A) Criteria for IQ4K—Level 2 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school
118.23(237A) Criteria for IQ4K—Level 3 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school
118.24(237A) Criteria for IQ4K—Level 4 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school
118.25(237A) Criteria for IQ4K—Level 5 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school
118.26(237A) Rating standards for school-aged only programs
118.27(237A) Criteria for IQ4K—Level 1 school-aged only programs
118.28(237A) Criteria for IQ4K—Level 2 school-aged only programs
118.29(237A) Criteria for IQ4K—Level 3 school-aged only programs
118.30(237A) Criteria for IQ4K—Level 4 school-aged only programs
118.31(237A) Criteria for IQ4K—Level 5 school-aged only programs
118.32(237A) Rating standards for registered child development homes
118.33(237A) Criteria for IQ4K—Level 1 rating standards for registered child development homes
118.34(237A) Criteria for IQ4K—Level 2 rating standards for registered child development homes
118.35(237A) Criteria for IQ4K—Level 3 rating standards for registered child development homes
118.36(237A) Criteria for IQ4K—Level 4 rating standards for registered child development homes
118.37(237A) Criteria for IQ4K—Level 5 rating standards for registered child development homes
118.38(237A) Award of quality rating

118.39(237A) Adverse actions

CHAPTER 119
RECORD CHECK EVALUATIONS FOR CERTAIN EMPLOYERS AND EDUCATIONAL TRAINING PROGRAMS

119.1(135B,135C) Definitions
119.2(135B,135C) When record check evaluations are requested
119.3(135C) Request for evaluation
119.4(135B,135C) Completion of evaluation
119.5(135B,135C) Appeal rights

CHAPTER 120
Reserved

CHAPTER 121
EARLY CHILDHOOD IOWA INITIATIVE

121.1(256I) Definitions
121.2(256I) Early childhood Iowa state board responsibility
121.3(256I) Early childhood Iowa coordination staff
121.4(256I) Early childhood Iowa areas

CHAPTER 122
FISCAL OVERSIGHT OF THE EARLY CHILDHOOD IOWA INITIATIVE

122.1(256I) Definitions
122.2(256I) Fiscal oversight

CERTIFICATE OF NEED PROGRAM

CHAPTER 123
CERTIFICATE OF NEED PROGRAM

123.1(135) Definition
123.2(135) Determination of reviewability
123.3(135) Submission of application
123.4(135) Organizational procedures
123.5(135) Summary review
123.6(135) Extension of review time
123.7(135) Rehearing of certificate of need decision
123.8(135) Finality
123.9(135) Request for extension of certificate
123.10(135) Application changes after approval
123.11(135) Sanctions

CHAPTER 124
STANDARDS FOR CERTIFICATE OF NEED REVIEW

124.1(135) Computerized tomography standards
124.2(135) Long-term care
124.3(135) MRI services standards
124.4(135) PET services standards

CHAPTER 125
KINSHIP FOSTER CARE APPROVAL STANDARDS

125.1(237) Definitions
125.2(237) Application for approval
125.3(237) Denial
125.4(237) Approval procedure
125.5(237) Involvement of kin
125.6(237) Information on the child placed in the home
125.7(237) Record checks
125.8(237) Medical examinations and health care of the child
125.9(237) Training and discipline of child

125.10(237) Emergency care and release of child
125.11(237) Changes in kinship foster care home
125.12(237) Liability

CHAPTERS 126 to 129
Reserved

TITLE XIII
SERVICE ADMINISTRATION

CHAPTER 130
GENERAL PROVISIONS

130.1(234) Definitions
130.2(234) Application
130.3(234) Eligibility
130.4(234) Adverse service actions
130.5(234) Social casework
130.6(234) Case plan
130.7(234) Entitlement

CHAPTERS 131 and 132
Reserved

CHAPTER 133
IV-A EMERGENCY ASSISTANCE PROGRAM

133.1(235) Definitions
133.2(235) Application
133.3(235) Eligibility
133.4(235) Method of service provision
133.5(235) Duration of services
133.6(235) Discontinuance of the program

CHAPTERS 134 to 141
Reserved

CHAPTER 142
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

142.1(232) Compact agreement
142.2(232) Compact administrator
142.3(232) Article III(a) procedures
142.4(232) Article III(c)
142.5(232) Article V(c)
142.6(232) Article VIII(a)
142.7(232) Applicability
142.8(232) NEICE database

CHAPTER 143
INTERSTATE COMPACT FOR JUVENILES

143.1(232) Compact agreement
143.2(232) Compact administrator
143.3(232) Sending a juvenile out of Iowa under the compact
143.4(232) Receiving cases in Iowa under the interstate compact
143.5(232) Runaways

CHAPTERS 144 to 149
Reserved

TITLE XIV
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150
Reserved

CHAPTER 151
JUVENILE COURT-ORDERED SERVICES

151.1(232) Definitions
151.2(232) Administration of funds for court-ordered services
151.3(232) Use of other funding sources
151.4(232) Expenses

CHAPTER 152
FOSTER CARE CONTRACTING

152.1(234) Definitions
152.2(234) Conditions of participation
152.3(234) Provider reviews
152.4(234) Sanctions against providers
152.5(234) Adverse actions

CHAPTER 153
FUNDING FOR LOCAL SERVICES

153.1(234) Development of pre-expenditure report and intended use plan
153.2(234) Amendment to pre-expenditure report and intended use plan
153.3(234) Service availability
153.4(234) Allocation of block grant funds
153.5(234) Expenditure of supplemental funds

CHAPTER 154
Reserved

CHAPTER 155
CHILD ABUSE PREVENTION PROGRAM

155.1(235A) Definitions
155.2(235A) Contract for program administration
155.3(235A) Awarding of grants
155.4(235A) Grantee requirements

CHAPTER 156
PAYMENTS FOR FOSTER CARE

156.1(234) Definitions
156.2(234) Foster care recovery
156.3(234) Rate of maintenance payment for foster family care
156.4(234) Kinship caregiver payment
156.5(234) Additional payments
156.6(234) Rate of payment for foster group care
156.7(234) Payment for reserve bed days
156.8(234) Emergency juvenile shelter care payment
156.9(234) Supervised apartment living
156.10(234,252C) Voluntary placements
156.11(234) Child's earnings
156.12(234) Trust funds and investments
156.13(234) Preadoptive homes
156.14(234) Eligibility for foster care payment

CHAPTER 157
Reserved

CHAPTER 158
FOSTER HOME INSURANCE FUND

158.1(237) Definitions

158.2(237) Payments from the foster home insurance fund
158.3(237) Payment limits
158.4(237) Claim procedures

CHAPTERS 159 to 163
Reserved

CHAPTER 164
MORE OPTIONS FOR MATERNAL SUPPORT (MOMS) PROGRAM

164.1(217) Definitions
164.2(217) Pregnancy support services
164.3(217) Program administrator responsibilities
164.4(217) Client feedback
164.5(217) Appeals

CHAPTER 165
Reserved

CHAPTER 166
QUALITY IMPROVEMENT INITIATIVE GRANTS

166.1(249A) Definitions
166.2(249A) Availability of grants
166.3(249A) Grant eligibility
166.4(249A) Grant application process and selection of proposals
166.5(249A) Project contracts

CHAPTER 167
JUVENILE DETENTION REIMBURSEMENT

167.1(232) Definitions
167.2(232) Availability of funds
167.3(232) Eligible detention homes
167.4(232) Available reimbursement
167.5(232) Reimbursement by the department

CHAPTERS 168 and 169
Reserved

TITLE XV
INDIVIDUAL AND FAMILY SUPPORT AND PROTECTIVE SERVICES

CHAPTER 170
CHILD CARE SERVICES

170.1(237A) Definitions
170.2(237A,239B) Eligibility requirements
170.3(237A,239B) Application and determination of eligibility
170.4(237A) Elements of service provision
170.5(237A) Adverse actions
170.6(237A) Appeals
170.7(237A) Provider fraud
170.8(237A) Client fraud
170.9(237A) Child care assistance overpayments

CHAPTER 171
Reserved

CHAPTER 172
FAMILY-CENTERED SERVICES

172.1(234) Definitions
172.2(234) Family-centered services
172.3(234) Authorization

172.4(234) Client appeals

CHAPTER 173
Reserved

CHAPTER 174
STUDENT ABUSE REPORTS AND INVESTIGATIONS

174.1(232E) Application—not exclusive
174.2(232E) Definitions
174.3(232E) Abuse intake process—report of alleged student abuse
174.4(232E) Student abuse intake process—credible reports
174.5(232E) Options if report dismissed or rejected during student abuse intake
174.6(232E) Notification of school authorities and identifiable source regarding credible reports
174.7(232E) Investigation—duties of an investigator and school authorities
174.8(232E) School employee resignation during pendency of investigation
174.9(232E) Substantiated report—right of school employee to contested case proceedings and further review
174.10(232E) Case record retention—protection of identifiable source—disclosure limitations
174.11(232E) Substantial compliance

CHAPTER 175
ABUSE OF CHILDREN

DIVISION I
CHILD ABUSE

175.1 to 175.20 Reserved

DIVISION II
CHILD ABUSE ASSESSMENT

175.21(232,235A) Definitions
175.22(232) Receipt of a report of suspected child abuse
175.23(232) Sources of report of suspected child abuse
175.24(232) Assessment intake process
175.25(232) Assessment process
175.26(232) Completion of a written assessment report
175.27(232) Contact with juvenile court or the county attorney
175.28(232) Consultation with health practitioners or mental health professionals
175.29(232) Consultation with law enforcement
175.30(232) Information shared with law enforcement
175.31(232) Completion of required correspondence
175.32(232,235A) Case records
175.33(232,235A) Child protection centers
175.34(232) Department-operated facilities
175.35(232,235A) Jurisdiction of assessments
175.36(235A) Multidisciplinary teams
175.37(232) Community education
175.38(235) Written authorizations
175.39(232) Founded child abuse
175.40 Reserved
175.41(235A) Access to child abuse information
175.42(235A) Person conducting research
175.43(235A) Child protection services citizen review panels

CHAPTER 176
DEPENDENT ADULT ABUSE

176.1(235B) Definitions
176.2(235B) Denial of critical care
176.3(235B) Appropriate report
176.4(235B) Reporters
176.5(235B) Reporting procedure
176.6(235B) Duties of the department upon receipt of report

176.7(235B) Investigation
176.8(235B) Registry records
176.9(235B) Dependent adult abuse information disseminated
176.10(235B) Examination of information
176.11(235B) Dependent adult abuse information registry
176.12(235B) Multidisciplinary teams
176.13(235B) Request for correction or expungement

CHAPTER 177
IN-HOME HEALTH-RELATED CARE

177.1(249) Definitions
177.2(249) Eligibility and application
177.3(249) Qualifications of providers of health care services
177.4(249) Physician's certification
177.5(249A) Department duties
177.6(249) Supervising practitioner duties
177.7(249) Written agreements
177.8(249) Payment
177.9(249) Termination conditions

CHAPTERS 178 to 186
Reserved

CHAPTER 187
AFTERCARE SERVICES PROGRAM

187.1(234) Aftercare services program eligibility requirements
187.2(234) Services and supports provided
187.3(234) Termination of aftercare services
187.4(234) Waiting list
187.5(234) Administration
187.6(234) Appeal

CHAPTERS 188 to 199
Reserved

TITLE XVI
ALTERNATIVE LIVING

CHAPTER 200
ADOPTION SERVICES

200.1(600) Definitions
200.2(600) Application
200.3(600) Adoption services
200.4(600) Termination of parental rights
200.5(600) Interstate placements
200.6 and 200.7 Reserved
200.8(600) Removal of child from preadoptive family
200.9 Reserved
200.10(600) Requests for access to information for research or treatment
200.11(600) Requests for information for purposes other than research or treatment

CHAPTER 201
SUBSIDIZED ADOPTIONS

201.1(600) Administration
201.2(600) Definitions
201.3(600) Conditions of eligibility or ineligibility
201.4(600) Application
201.5(600) Negotiation of amount of presubsidy or subsidy
201.6(600) Types of subsidy
201.7(600) Determination of ongoing subsidy eligibility and suspension of subsidy payments

201.8(600) Termination of subsidy
201.9(600) Reinstatement of subsidy
201.10(600) New application
201.11(600) Medical assistance based on residency
201.12(600) Presubsidy recovery

CHAPTER 202
FOSTER CARE PLACEMENT AND SERVICES

202.1(234) Definitions
202.2(234) Eligibility
202.3(234) Voluntary placements
202.4(234) Selection of facility
202.5(234) Preplacement
202.6(234) Placement
202.7(234) Out-of-area placements
202.8(234) Out-of-state placements
202.9(234) Supervised apartment living
202.10(234) Services to foster parents
202.11(234) Services to the child
202.12(234) Services to parents
202.13(234) Removal of the child
202.14(234) Termination
202.15(234) Case permanency plan
202.16(135H) Department approval of need for a psychiatric medical institution for children
202.17(232) Area group care targets
202.18(235) Local transition committees

CHAPTER 203
IOWA ADOPTION EXCHANGE

203.1(232) Definitions
203.2(232) Children to be registered on the exchange system
203.3(232) Families to be registered on the exchange system
203.4(232) Matching process

CHAPTER 204
SUBSIDIZED GUARDIANSHIP PROGRAM

204.1(234) Definitions
204.2(234) Eligibility
204.3(234) Application
204.4(234) Negotiation of amount of subsidy
204.5(234) Parental liability
204.6(234) Determination of ongoing subsidy eligibility and suspension of subsidy payments
204.7(234) Termination of subsidy
204.8(234) Reinstatement of subsidy
204.9(234) Appeals
204.10(234) Medical assistance

CHAPTERS 205 to 209
Reserved

TITLE XVII
AGING AND DISABILITY SERVICES

CHAPTERS 210 to 220
Reserved

CHAPTER 221
DISABILITY SERVICES DEFINITIONS

221.1(225A) Definitions

CHAPTER 222
DISABILITY SERVICES ADVISORY COUNCILS

222.1(231) Appointment
222.2(231) Officers
222.3(231) Meetings
222.4(231) Subcommittees
222.5(231) Expenses of preparedness advisory committee voting members
222.6(231) Council composition

CHAPTER 223
DISABILITY SERVICES

223.1(231) Eligibility for LTSS disability services
223.2(231) Option for waiting lists for disability services
223.3(231) Access standards
223.4(231) Appeal rights

CHAPTER 224
AGING AND DISABILITY RESOURCE CENTERS

224.1(231) Definitions
224.2(231) Department responsibilities
224.3(231) ADRC member organizations
224.4(231) ADRC member organization responsibilities
224.5(231) ADRC member organization staff requirements and background checks
224.6(231) Services
224.7(231) Grievances
224.8(231) Reporting and records authority
224.9(231) Confidentiality

CHAPTER 225
AGING SERVICES

225.1(231) Applicability
225.2(231) Definitions
225.3(231) Aging network
225.4(231) Conflict of interest

CHAPTER 226
STATE UNIT ON AGING RESPONSIBILITIES

226.1(231) Designated state unit on aging
226.2(231) Policies and procedures
226.3(231) Public input
226.4(231) State plan on aging
226.5(231) Designation of and changes to PSAs
226.6(231) Designating area agencies on aging
226.7(231) Withdrawal of designation of area agency on aging
226.8(231) Appeals to withdrawal of area agency on aging designation
226.9(231) Area plan on aging reviews and approvals
226.10(231) Intrastate funding formula
226.11(231) Evaluation and compliance
226.12(231) Data management
226.13(231) State agency Title III and Title VI coordination responsibilities
226.14(231) Emergency and disaster requirements
226.15(231) Prevention of elder abuse, neglect, and exploitation
226.16(231) State legal assistance development program

CHAPTER 227
AREA AGENCY ON AGING RESPONSIBILITIES

227.1(231) Area agency on aging responsibilities
227.2(231) Board of directors
227.3(231) Staffing

227.4(231) Conflicts of interest
227.5(231) Policies and procedures
227.6(231) Public participation
227.7(231) Advocacy
227.8(231) Area plan on aging
227.9(231) Title III and Title VI coordination
227.10(231) Fiscal responsibilities
227.11(231) Compliance monitoring
227.12(231) Quality performance
227.13(231) Data collection, sharing, and confidentiality
227.14(231) Reporting
227.15(231) Emergency and disaster requirements
227.16(231) Direct service provisions
227.17(231) Grievance

CHAPTER 228
DELIVERY OF AGING SERVICES

228.1(231) Aging service delivery
228.2(231) Eligibility
228.3(231) Supportive services and senior centers
228.4(231) Nutrition services
228.5(231) Evidence-based disease prevention and health promotion services
228.6(231) Family caregiver support services
228.7(231) Prevention of elder abuse, neglect, and exploitation
228.8(231) Service prioritization
228.9(231) Service wait lists, unmet needs, and other changes to service
228.10(231) Voluntary contributions
228.11(231) Membership fees
228.12(231) Prohibition against means testing

CHAPTER 229
DATA COLLECTION

229.1(231) Authority

CHAPTER 230
LONG-TERM CARE OMBUDSMAN

230.1(231) Definitions
230.2(231) Interference
230.3(231) Monetary civil penalties—basis
230.4(231) Monetary civil penalties—notice of penalty
230.5(231) Monetary civil penalties—appeals
230.6(231) Certified volunteer long-term care ombudsman program
230.7(231) Managed care ombudsman services

CHAPTER 231
OFFICE OF PUBLIC GUARDIAN

231.1(231E,633) Purpose
231.2(231E,633) Definitions
231.3(231E,633) Public guardian qualifications
231.4(231E,633) Ethics and standards of practice
231.5(231E,633) Staffing ratio
231.6(231E,633) Conflict of interest
231.7(231E,633) Individuals eligible for services
231.8(231E,633) Application and intake process—guardianship, conservatorship, and representative payee
231.9(231E,633) Case records
231.10(231E,633) Confidentiality
231.11(231E,633) Termination or limitation
231.12(231E,633) Service fees
231.13(231E,633) Denial of services—appeal

231.14(231E,633) Contesting the actions of a guardian, conservator, or representative payee

CHAPTERS 232 to 299
Reserved

TITLE XVIII
BEHAVIORIAL HEALTH SERVICES

CHAPTER 300
DEFINITIONS

300.1(225A) Definitions

CHAPTER 301
BEHAVIORAL HEALTH SERVICE SYSTEM ELIGIBILITY AND SERVICES

301.1(225A) Individual eligibility for behavioral health service system funding
301.2(225A) The behavioral health care continuum
301.3(225A) Provider qualifications
301.4(225A) Appeal rights

CHAPTER 302
BEHAVIORAL HEALTH ADMINISTRATIVE SERVICE ORGANIZATIONS

302.1(225A) Implementation and maintenance of programs and services
302.2(225A) Service availability and accessibility
302.3(225A) Provider oversight and monitoring

CHAPTER 303
Reserved

CHAPTER 304
DISTRICT BEHAVIORAL HEALTH ADVISORY COUNCILS

304.1(225A) Definitions
304.2(225A) Appointment
304.3(225A) Officers
304.4(225A) Meetings
304.5(225A) Subcommittees
304.6(225A) Advisory council composition

CHAPTER 305
MENTAL HEALTH ADVOCATES

305.1(229) Advocate appointment and qualifications
305.2(229) Advocate assignment
305.3(229) Advocate responsibilities
305.4(229) County responsibilities
305.5(229) Data collection requirements
305.6(229) Quality assurance system

CHAPTER 306
OPIOID SETTLEMENT FUND DISBURSEMENT

306.1(12) Definition
306.2(12) Methodology
306.3(12) Outcome measurement
306.4(12) Annual report

CHAPTERS 307 to 309
Reserved

CHAPTER 310
DATA COLLECTION

310.1(225A) Authority

CHAPTERS 311 to 2503
Reserved

CHAPTER 2504
RULE WAIVERS

2504.3(17A) Evaluation

CHAPTER 2505
FAIR INFORMATION PRACTICES

2505.1(17A,22) Definitions
2505.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination
2505.7(17A,22) Consent to disclosure by the subject of a confidential record
2505.9(22,252G) Personally identifiable information

CHAPTER 2506
CONTESTED CASES

2506.2(17A) Definitions
2506.3(17A) Time obligations
2506.4(17A) Electronic requests for contested case proceeding
2506.5(17A) Notice of hearing
2506.6(17A) Presiding officer
2506.10(17A) Consolidation—severance
2506.11(17A) Pleadings
2506.12(17A) Electronic service and filing of pleadings and other papers
2506.18(17A) Withdrawals
2506.20(17A) Hearing procedures
2506.27(17A) Appeals and review
2506.32(17A) Timelines for contested case hearings
2506.33(17A) Medical assistance expedited review
2506.34(17A) SNAP administrative disqualification hearings
2506.35(17A) Continuation and reinstatement of benefits

GENERAL DEPARTMENTAL PROCEDURES

TITLE I

CHAPTER 1
DEPARTMENT ORGANIZATION AND GENERAL DEFINITIONS

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

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441—1.1(217) History and mission. The Iowa department of health and human services was established in 2022 pursuant to 2022 Iowa Acts, House File 2578, and fully codified pursuant to 2023 Iowa Acts, Senate File 514. The authority delegated to the department had previously been delegated to the departments of human services, public health, aging, and human rights; the Iowa commission on volunteer service; the child advocacy board and the department of inspections and appeals. In 2023, the general assembly combined these agencies and programs to create the department of health and human services. The department's mission is published on the department's website.
[**ARC 8045C**, IAB 5/29/24, effective 7/3/24]

441—1.2(217) Definitions. For the purposes of the department's rules, unless otherwise defined:

"Council" means the health and human services council.

"Department" means the department of health and human services.

"Director" means the director of health and human services.

"Electronic signature" means a confidential personalized digital key, code, or number that is used for secure electronic data transmission and that identifies and authenticates the signatory.
[**ARC 8045C**, IAB 5/29/24, effective 7/3/24]

441—1.3(217) Department structure.

1.3(1) *General.* The department's organizational structure consists of the council, the director and such divisions as the director may from time to time create.

1.3(2) *Director.* The department director is appointed pursuant to the requirements in Iowa Code section 217.5.

1.3(3) *Delegation of director authority.* The director may designate employee(s) to administer the department in the director's absence. The director may also delegate the director's authority to administer the department to other employees as determined necessary for efficient and effective department operations. Delegations of the director's authority will be documented by the department.

1.3(4) *Divisions.* The director may from time to time reorganize the department into administrative divisions to most efficiently and effectively carry out the department's responsibilities. Reorganization may include creating new divisions, eliminating existing divisions, or combining divisions as the director deems necessary.
[**ARC 8045C**, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 7/8/26]

441—1.4(217) Information. The general public may obtain information about the department by contacting the department at its offices located at 321 E. 12th Street, Des Moines, Iowa 50319, telephone 515.281.5452, or through the department's website.
[**ARC 8045C**, IAB 5/29/24, effective 7/3/24]

441—1.5(217) Health and human services council. The council is established in Iowa Code section 217.2 and its duties are in Iowa Code section 217.3. Meetings of the council and any ad hoc committee it may establish are conducted in accordance with the provisions of Iowa Code chapter 21.
[**ARC 8045C**, IAB 5/29/24, effective 7/3/24]

441—1.6(217) State council on developmental disabilities. The state developmental disabilities council and its duties are established in 42 U.S.C. §15025.

1.6(1) *Designated state agency.* The department serves as the designated state agency.

1.6(2) *Membership.* The council consists of up to 26 members appointed by the governor. Members serve three-year terms. Appointments are staggered so at least one-third of the members are appointed each year. The nonattendance provisions of Iowa Code section 69.15 apply to the council's members.

1.6(3) *Meetings.* Meetings of the council are conducted in accordance with the provisions of Iowa Code chapter 21.

1.6(4) *Council information.* The general public may obtain information about the council at its offices located at 700 2nd Avenue, Suite 101, Des Moines, Iowa, 50309; telephone 800.452.1936; or the website iowaddcouncil.org.

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[1] The effective date of **ARC 7711C** was corrected to July 1, 2024, in the April 3, 2024, Iowa Administrative Bulletin.

CHAPTER 2
CONTRACTING OUT DEPARTMENT OF HUMAN SERVICES EMPLOYEES AND PROPERTY

Rescinded **ARC 8108C**, IAB 7/10/24, effective 8/14/24

CHAPTER 3
DEPARTMENT PROCEDURE FOR RULEMAKING

[Ch 3, 1973 IDR, renumbered as [770] Ch 77]
[Prior to 7/1/83, Social Services[770] Ch 3]
[Prior to 2/11/87, Human Services[498]]

Rescinded by 2026 Iowa Acts, Senate File 2463, section 4, effective July 1, 2026. See Uniform Rules on Agency Procedure at 7—Chapters 2500 through 2506 and any corresponding rules adopted by this agency.

CHAPTER 4
PETITIONS FOR RULEMAKING

[Ch 4, 1974 IDR, renumbered as [770] Ch 78]
[Prior to 7/1/83, Social Services[770] Ch 4]
[Prior to 2/11/87, Human Services[498]]

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CHAPTER 5
DECLARATORY ORDERS

[Ch 5, 1973 IDR, renumbered as [770] Ch 79]
[Prior to 7/1/83, Social Services[770] Ch 5]
[Prior to 2/11/87, Human Services[498]]

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CHAPTER 6
WAIVERS OF HEALTH AND HUMAN SERVICES ADMINISTRATIVE RULES

[Prior to 6/28/23, see Public Health Department[641] Ch 178]

Rescinded by 2026 Iowa Acts, Senate File 2463, section 4, effective July 1, 2026. See Uniform Rules on Agency Procedure at 7—Chapters 2500 through 2506 and any corresponding rules adopted by this agency.

CHAPTER 7
APPEALS AND HEARINGS

[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]
[Prior to 7/1/83, Social Services[770] Ch 7]
[Prior to 2/11/87, Human Services[498]]

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CHAPTER 8
PAYMENT OF SMALL CLAIMS

[Prior to 7/1/83, Social Services[770] Ch 8]
[Prior to 2/11/87, Human Services[498]]

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

441—8.1(217) Authorization to reimburse. The department will follow Iowa Code section 217.23(2) when reimbursing employees for personal items damaged or destroyed by clients of the department during the employee's tour of duty. The claimant shall provide the department with a detailed written account of the incident, including an estimated cost of repair or replacement.

This rule is intended to implement Iowa Code section 217.23.

[**ARC 8066C**, IAB 6/12/24, effective 7/17/24]

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CHAPTER 9
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

Rescinded by 2026 Iowa Acts, Senate File 2463, section 4, effective July 1, 2026. See Uniform Rules on Agency Procedure at 7—Chapters 2500 through 2506 and any corresponding rules adopted by this agency.

CHAPTER 10
COLLECTION OF DELINQUENT DEBTS

[Prior to 1/24/24, see Public Health Department[641] Ch 179]
Rescinded **ARC 8205C**, IAB 9/4/24, effective 10/9/24

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

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

441—11.1(217) Definitions.

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

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

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

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

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

"Written notification" means the notification sent to a debtor by the department on a form issued by the department.

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

441—11.2(217) Establishment of claim.

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

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

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

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

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

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

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

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

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

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

(1) First to all debts that have an agreement in chronological order of discovery, and

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

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

(1) First to state-only debts in chronological order of discovery,

(2) Then to intentional program violation (IPV) debts in chronological order of discovery,

(3) Then to inadvertent household error (IHE) debts in chronological order of discovery, and

(4) Then to agency error debts in chronological order of discovery.

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

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

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

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

11.4(1) *Criteria for setoff.*

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

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

(2) A repayment agreement is not current, and

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

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

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

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

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

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

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

b. The department makes claim against the debtor.

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

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

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

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

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

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

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

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

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

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

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

11.5(1) *Criteria for setoff.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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CHAPTER 12
VOLUNTEER SERVICES

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

Rescinded **ARC 6272C**, IAB 4/6/22, effective 6/1/22

CHAPTER 13
PROGRAM EVALUATION

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

441—13.1(234,239B,249A,514I) Definitions.

"Active case" means a case that was receiving assistance for the month of review.

"Case record" means the record used to establish a client's eligibility.

"Client" means a current or former applicant or recipient of the family investment program (FIP), Supplemental Nutrition Assistance Program (SNAP), child care assistance program, or medical assistance program.

"Field investigation" means a contact involving the public or other agencies to obtain information about the client's circumstances for the appropriate month of review.

"Medical assistance programs" means those programs funded by Medicaid or the Children's Health Insurance Program (CHIP).

"Month of review" means the specific calendar or fiscal month for which the assistance under review is received.

"Negative case" means a case that was terminated or denied assistance in the month of review.

"Public assistance programs" means those programs involving federal funds, i.e., FIP, SNAP, child care assistance program, and medical assistance program.

"Random sample" means a systematic (or every nth unit) sample drawn monthly for which each item in the universe has an equal probability of being selected. Sample size is determined by federal guidelines or state corrective action needs.

"State policies" means the rules and regulations used by the department to administer FIP, SNAP, child care assistance program, and medical assistance program.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, 249A.4 and 514I.4.

[**ARC 8067C**, IAB 6/12/24, effective 7/17/24]

441—13.2(234,239B,249A,514I) Review of public assistance records by the department.

13.2(1) Authorized representatives of the department shall have the right to review case records to determine the following:

a. Whether the client has provided complete, correct and accurate information to the department to be used in the determination of the assistance benefits.

b. Whether the department has correctly administered the state policies in determination of assistance for the public assistance programs.

c. Whether overpayments or underpayments have been made correctly to the public assistance client during the month of review.

d. Whether there is indication of fraudulent practice or abuse of the public assistance programs by either the client or department.

13.2(2) All pertinent case records within the department may be used by the reviewer to assist in substantiating an accurate reflection as to the correctness of the assistance received by the client.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, 249A.4 and 514I.4.

[**ARC 8067C**, IAB 6/12/24, effective 7/17/24]

441—13.3(234,239B,249A,514I) Cases to be reviewed. Any active or negative public assistance case may be reviewed at any time at the discretion of the department to:

13.3(1) Ensure federal and state requirements for quality control are met.

13.3(2) Detect error prone case issues to assist in corrective action.

13.3(3) Maintain public assistance program integrity.

This rule is intended to implement Iowa Code sections 234.6, 234.12, 239B.4, 249A.4, and 514I.4.

[**ARC 8067C**, IAB 6/12/24, effective 7/17/24]

441—13.4(234,239B,249A,514I) Notification of review. On positive case actions, clients will be notified, either orally or in writing, that their case has been selected for review when contact is required by federal guidelines, or when contact is allowed and additional information is required to complete the review. The client will be contacted in a negative case only if a discrepancy exists that cannot be resolved from the case record and contact is allowed by federal guidelines.

This rule is intended to implement Iowa Code sections 234.6, 234.12, 239B.4, 249A.4, and 514I.4.

[**ARC 8067C**, IAB 6/12/24, effective 7/17/24]

441—13.5(234,239B,249A,514I) Review procedure. The department will select the appropriate method of conducting the review.

13.5(1) A random sampling of active and negative case actions will be used to determine the case records to be studied.

13.5(2) The case record will be analyzed for discrepancies and correct application of policies and procedures and will be used as the basis for a field investigation.

13.5(3) Client interviews are required as follows:

a. Personal interviews are required on all active SNAP reviews.

b. An appointment letter may be sent to the client by the department to schedule or confirm the appointment date, time and location.

c. Client contacts are only required in negative case reviews when there is a discrepancy that cannot be resolved from the case record.

13.5(4) Collateral contacts are made whenever the client is unable to furnish information needed or the reviewer needs additional information to establish the correctness of eligibility and payment but only when allowed by federal guidelines. Verification to confirm the accuracy of statements or information may be obtained by documentary evidence or a contact with a third party.

a. The client shall release specific information whenever necessary to verify information essential to the determination of eligibility and payment.

b. Should the client refuse to authorize the department to contact an informant to verify information that is necessary for the completion of the review, collateral contacts will still be made through use of the general release statement contained in the financial support application or the review/recertification eligibility document.

This rule is intended to implement Iowa Code sections 234.6, 234.12, 239B.4, 249A.4, and 514I.4.

[**ARC 8067C**, IAB 6/12/24, effective 7/17/24]

441—13.6(234) Failure to cooperate. Client cooperation with quality control is a program eligibility requirement as set forth in rule 441—65.3(234). When quality control determines that a client has refused to cooperate with the review process, the client is no longer eligible for the program benefits and will not be eligible for the program benefits until the client has cooperated.

This rule is intended to implement Iowa Code section 234.12.

[**ARC 8067C**, IAB 6/12/24, effective 7/17/24]

441—13.7(234,239B,249A,514I) Report of findings. The quality control review findings are used by the department in the following ways:

13.7(1) To take the appropriate case action where an overpayment or underpayment has been found in a client's case record.

13.7(2) To identify error-prone program issues to be used in planning a department corrective action plan.

13.7(3) To determine the error rate used to establish state agency liability.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, 249A.4, and 514I.4.

[**ARC 8067C**, IAB 6/12/24, effective 7/17/24]

441—13.8(234,237A,239B,249A,514I) Federal review. A sample of cases may also be reviewed by the applicable federal agency to determine the correctness of the department's action or of the department's review of the case.

This rule is intended to implement Iowa Code sections 234.12, 237A.12, 239B.4, 249A.4, and 514I.4.

[**ARC 8067C**, IAB 6/12/24, effective 7/17/24]

[Filed 3/26/87, Notice 1/28/87—published 4/22/87, effective 6/1/87]
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[Filed ARC 8067C (Notice ARC 7364C, IAB 1/24/24), IAB 6/12/24, effective 7/17/24]

CHAPTER 14
OFFSET OF COUNTY DEBTS OWED DEPARTMENT
Rescinded **ARC 6348C**, IAB 6/15/22, effective 8/1/22

CHAPTER 15
RESOLUTION OF LEGAL SETTLEMENT DISPUTES
Rescinded **ARC 4610C**, IAB 8/14/19, effective 9/18/19
[Editorial change: IAC Supplement 8/14/19]

CHAPTER 16
NOTICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/26/30

441—16.1(17A) Definitions.

"Adequate notice" means any notice of decision or notice of action issued by the department or on the department's behalf that includes all the following information:

1. A description of the action taken;
2. The effective date of the action;
3. The specific reasons supporting the action, stated language likely to be understood by the average program applicant or enrollee;
4. References to applicable provisions of law supporting the action;
5. An explanation of the right to appeal; and
6. The circumstances under which assistance is continued when an appeal is filed.

"Adverse benefit determination" means any adverse action taken by the department regarding a program administered by the department or on the department's behalf, excluding department decisions about requests for waivers of administrative rules.

"Assistance program" means a program administered by the department or on the department's behalf through which qualifying individuals receive benefits or services.

"Enrollee" means any applicant for, or recipient of, benefits or services pursuant to an assistance program.

"Timely" means that the notice is sent at least ten calendar days before the date the adverse benefit determination would become effective. The timely notice period begins on the day after the notice is sent.

[**ARC 8897C**, IAB 2/19/25, effective 3/26/25]

441—16.2(17A) Notices.

16.2(1) *Written timely and adequate notice.* When required by federal or state law, the department will provide written timely and adequate notice of the right to appeal any adverse benefit determination that affects an individual who is applying for, or receiving benefits from, an assistance program. The department will also provide written timely notice of pending actions for a federal tax or debtor offset.

16.2(2) *Adequate notice.* The department will give adequate notice of the approval or denial of assistance or services and the approval or denial of a license, certification, approval, registration, or accreditation.

16.2(3) *Dispensing with timely notice.* Timely notice may be dispensed with, but adequate notice will be sent no later than the date benefits would have been issued, when:

a. There is factual information confirming the death of the enrollee or of the family investment program payee and there is no relative available to serve as a new payee.

b. The enrollee provides a clearly written, signed statement that the enrollee no longer wishes to receive assistance, or gives information that requires termination or reduction of assistance, and the enrollee has indicated, in writing, that the enrollee understands that the consequence of supplying the information is termination or reduction of assistance.

c. The enrollee has been admitted or committed to an institution that does not qualify for payment under an assistance program.

d. The enrollee has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

e. The whereabouts of the enrollee are unknown and mail directed to the enrollee has been returned by the post office indicating no known forwarding address. When the whereabouts of the enrollee become known during the payment period covered by the returned warrant, the warrant will be made available to the enrollee.

f. The department establishes that the enrollee has been accepted for assistance in another state.

g. Cash assistance or the supplemental nutrition assistance program is changed because a child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care.

h. A change in the level of medical care is prescribed by the enrollee's physician.

i. A special allowance or service granted for a specific period is terminated and the enrollee has been informed in writing at the time of initiation that the allowance or service will terminate at the end of the specified period.

j. The notice involves an adverse determination made with regard to the preadmission screening requirements.

k. The department terminates or reduces benefits or makes changes as described at 441—subrule 40.27(3) or rule 441—75.52(249A).

l. The department terminates benefits for failure to return a completed report form, as described in paragraph 16.3(3)*"k."*

m. The department approves or denies an application for assistance.

n. The department implements a mass change based on law or rule changes that affect a group of enrollees.

[**ARC 8897C**, IAB 2/19/25, effective 3/26/25]

These rules are intended to implement Iowa Code chapter 17A.

[Filed ARC 4973C (Notice ARC 4675C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]
[Filed ARC 8045C (Notice ARC 7358C, IAB 1/24/24), IAB 5/29/24, effective 7/3/24]
[Filed ARC 8897C (Notice ARC 8426C, IAB 11/27/24), IAB 2/19/25, effective 3/26/25]

TITLE II
CHAPTERS 17 to 21
Reserved

TITLE III
MENTAL HEALTH

CHAPTER 22
AUTISM SUPPORT PROGRAM

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

441—22.1(225D) Definitions.

"Administrator" means the entity selected by the department through a request for proposal process or other contractual arrangement to administer the autism support program.

"Applicant" means an individual on whose behalf an application has been submitted but who has not been identified as an eligible individual or an individual who has received a denial of eligibility for the program.

"Applied behavior analysis" or *"ABA"* means the same as described in Iowa Code section 225D.1.

"Autism" means "autism spectrum disorder" as defined in Iowa Code section 514C.28.

"Autism service provider" means the same as defined in Iowa Code section 225D.1.

"Autism support fund" or *"fund"* means the autism support fund created in Iowa Code section 225D.2.

"Autism support program" or *"program"* means the program created in Iowa Code section 225D.2 to provide funding for applied behavior analysis and care coordination for eligible individuals with a diagnosis of autism.

"Care coordination" means the coordination of services performed by the regional autism assistance program under Iowa Code section 256.35.

"Clinically relevant" means the same as defined in Iowa Code section 225D.1.

"Diagnostic assessment of autism" means the same as defined in Iowa Code section 225D.1.

"Eligible individual" means the same as defined in Iowa Code section 225D.1.

"Federal poverty level" or *"FPL"* means the same as defined in Iowa Code section 225D.1.

"Household income" means household income, reported on the tax return on which the eligible individual is claimed as a dependent, as determined using the modified adjusted gross income methodology pursuant to Section 2002 of the federal Patient Protection and Affordable Care Act, Public Law 111-148 as amended to August 1, 2026. If the eligible individual's parents live together and file separate tax returns, the income reported on both parents' tax returns must be combined.

"Household size" means the total number of personal and dependent exemptions claimed on the tax return on which the eligible individual is claimed as a dependent plus any child under the age of 19 living in the household who is claimed for tax purposes by a noncustodial parent through a release of claim to exemption by the custodial parent.

"Maximum amount of treatment" means a maximum of 24 months of applied behavior analysis funded by the autism support program. Months of service are not required to be consecutive.

"Maximum annual benefit" means a maximum annual benefit amount of $36,000 per year for autism support program services for an eligible individual. For the purposes of this program, the annual benefit is calculated by using as a starting date the date the first service is reimbursed by the program and an ending date 12 months from the starting date. Expenditures included in the calculation of the maximum annual benefit include reimbursements to autism service providers for provision of applied behavior analysis. Cost-sharing paid by the eligible individual is not included in the calculation of the individual's annual benefit.

"Medical assistance" or *"Medicaid"* means assistance provided under the medical assistance program pursuant to Iowa Code chapter 249A and Title XIX of the Social Security Act as amended to August 1, 2026.

"Month of service" means any month in which an individual receives at least one billable unit of applied behavior analysis service funded by the autism support program.

"Provider network" means a network of autism service providers approved by the department to provide services to eligible individuals through the autism support program.

"Regional autism assistance program" or *"RAP"* means the program outlined in Iowa Code section 256.35.

"Treatment plan" means the same as defined in Iowa Code section 225D.1.

[**ARC 0260D**, IAB 5/13/26, effective 7/1/26]

441—22.2(225D) Eligibility and application requirements. To be determined eligible for funding for services through the autism support program, an individual must meet the following requirements:

22.2(1) An individual shall submit an application to the department using a standardized application form available through the administrator's and the department's websites and from members of the provider network, RAP, and advocacy organizations.

22.2(2) An applicant for autism program services shall be less than the age of 14 at the time of application for the program. Proof of age must be provided at the time of application. An individual who reaches the age of 14 prior to receipt of the maximum benefits of the program may continue to receive services from the program in accordance with the individual's treatment plan, up to a maximum of 24 months of applied behavior analysis treatment.

22.2(3) An individual shall have a diagnosis of autism based on a diagnostic assessment of autism dated 24 months or less from the date of application for the program.

22.2(4) An individual shall be determined ineligible for coverage of applied behavior analysis services under the medical assistance program, Iowa Code section 514C.28 or 514C.31, or other private insurance coverage. Proof of insurance coverage and noneligibility for coverage for applied behavior analysis shall be provided at the time of application and shall include a written denial of coverage or a benefits summary indicating that the applied behavior analysis treatment or applied behavior analysis treatment is not a covered benefit for which the applicant is eligible under the Medicaid program, Iowa Code section 514C.28 or 514C.31, or other private insurance coverage.

22.2(5) An individual shall have a household income equal to or less than 500 percent of the federal poverty level. Information needed to determine household income using modified adjusted gross income methodology shall be identified on the program application. Household size will be determined according to the standards in this chapter. The information shall be provided at the time of application.

22.2(6) The department will provide to the parent or guardian a written notice of decision determining initial eligibility or denial within 30 calendar days of receipt of the application.

22.2(7) The department will refer an applicant determined to be an eligible individual to care coordination services. The referral will occur within five business days of determination of eligibility for the program. Care coordination services will be provided by RAP. Care coordination is not required as a condition of receiving services through the autism support program.

22.2(8) The department will provide information to an applicant determined to be an eligible individual regarding all available administrators. The eligible individual may choose any available administrator.

22.2(9) The administrator shall maintain a list of individuals determined eligible for the program but unable to access services due to lack of available providers and shall work to connect eligible individuals on the list to network providers.

22.2(10) The department will stop processing applications at the point where available funds are fully obligated for eligible individuals and additional eligible individuals would cause expenditures in excess of the funds available to the program. The department will maintain a waiting list of individuals denied access to the program due to lack of available funds. If additional funds become available, the department will contact individuals on the list in order of the earliest date and time of the receipt of the original application. The applicant will be allowed 30 calendar days to submit an updated application and any required information needed to determine eligibility. If the applicant does not submit required information, the applicant will be denied eligibility and removed from the waiting list maintained for individuals denied access to the program due to lack of funding. The age of the applicant at the time of the most recent application will be used when determining eligibility for the program.

[**ARC 0260D**, IAB 5/13/26, effective 7/1/26]

441—22.3(225D) Cost-sharing requirements and graduated schedule of cost sharing.

22.3(1) An individual with a household income equal to or greater than 200 percent of the federal poverty level, up to a maximum of 500 percent of the federal poverty level, will be subject to cost-sharing requirements. Cost sharing will be implemented incrementally up to a maximum of 15 percent of the costs of the services provided through the program for an individual with a household income equal to 500 percent of the federal poverty level. The following is a chart of the cost-sharing requirements:

Family income as a % of FPL	% of cost sharing of service costs	Family income as a % of FPL	% of cost sharing of service costs
200–209%	0.5%	350–359%	8.0%
210–219%	1.0%	360–369%	8.5%
220–229%	1.5%	370–379%	9.0%
230–239%	2.0%	380–389%	9.5%
240–249%	2.5%	390–399%	10.0%
250–259%	3.0%	400–409%	10.5%
260–269%	3.5%	410–419%	11.0%
270–279%	4.0%	420–429%	11.5%
280–289%	4.5%	430–439%	12.0%
290–299%	5.0%	440–449%	12.5%
300–309%	5.5%	450–459%	13.0%
310–319%	6.0%	460–469%	13.5%
320–329%	6.5%	470–479%	14.0%
330–339%	7.0%	480–489%	14.5%
340–349%	7.5%	490–500%	15.0%

22.3(2) An individual may request an exemption from cost sharing due to financial hardship. To qualify for an exemption, an individual shall submit written documentation to the department that the individual or the individual's family does not have the financial means to fulfill cost-sharing requirements.

22.3(3) Criteria to determine financial hardship include but are not limited to a change in income, change in employment of the parent or guardian, additional medical expenditures, other family members' health conditions, or other conditions that may affect the ability to fulfill cost-sharing requirements. The department will provide a written determination regarding eligibility for exemption from cost-sharing requirements. Eligibility for exemption from cost sharing expires at the end of the financial eligibility period.

[**ARC 0260D**, IAB 5/13/26, effective 7/1/26]

441—22.4(225D) Review of financial eligibility, cost-sharing requirements, exemption from cost sharing, and disenrollment in the program.

22.4(1) An eligible individual's continued financial eligibility for the program, cost-sharing requirements, and exemption from cost sharing will be determined on an annual basis.

22.4(2) The administrator shall request needed information from the eligible individual's parent or guardian for redetermination of financial eligibility, cost-sharing requirements, and exemption from cost sharing at least 30 days prior to the expiration of the eligible individual's eligibility period. The notice requesting information needed for renewal of eligibility shall include the ending date of eligibility for services.

22.4(3) The department will provide a written notice of decision determining ongoing eligibility or denial within 15 calendar days of receipt of the continued financial eligibility documentation.

22.4(4) If the signed application and verification of continuing eligibility are not received by the department by the last working day of the renewal month, the individual's eligibility for the program will be terminated.

22.4(5) Reasons for disenrollment in the autism support program include:

a. Death of the eligible individual.

b. The family no longer meets one or more of the eligibility criteria outlined in rule 441—22.2(225D).

c. The parent or legal guardian has failed to provide information required for redetermination of eligibility.

d. The eligible individual has failed to access authorized services for a period of three consecutive months and has not made arrangements with the autism service provider or administrator to access authorized services.

e. No funds are appropriated for the autism support program.

[**ARC 0260D**, IAB 5/13/26, effective 7/1/26]

441—22.5(225D) Initial-service authorization and renewal-of-service authorization.

22.5(1) All services reimbursed through the program shall be prior-authorized by the administrator.

22.5(2) An autism service provider shall submit an initial treatment plan to the administrator specifying a plan of treatment for a period of no more than six months. The initial treatment plan shall specify the amount of units of applied behavior analysis services requested for the eligible individual and include a baseline standardized assessment score.

22.5(3) Family engagement and participation are required for participation in the autism support program. Treatment plans shall identify specific activities and responsibilities of parents or guardians in the treatment plan.

22.5(4) The treatment plan shall reflect the autism service provider's engagement with the school in which the eligible individual is enrolled. Treatment plans shall identify specific actions taken by the autism service provider to engage the eligible individual's school and the results of such actions.

22.5(5) The treatment plan may include services provided by staff with a minimum of a bachelor's degree, or a registered behavior technician, both of whom provide treatment under the supervision of a behavior analyst or assistant behavior analyst licensed pursuant to Iowa Code chapter 154D.

22.5(6) For renewal or modification of service authorizations, the autism service provider shall submit an updated plan of treatment with a request for the number of units of applied behavior analysis the provider believes is medically necessary to address the eligible individual's ongoing treatment needs. The autism service provider shall also provide evidence of the eligible individual's progress on identified treatment goals. The administrator shall consider the eligible individual's updated standardized assessment score along with other clinical information when reviewing requests for renewal or modification of service authorizations. Ongoing service authorization requests shall not exceed six months in duration.

22.5(7) The administrator shall provide approval, request for modification, or denial within ten business days of receipt of all service authorization requests.

[**ARC 0260D**, IAB 5/13/26, effective 7/1/26]

441—22.6(225D) Provider network. The administrator shall establish and maintain a network of department-approved autism service providers so that applied behavior analysis services are available to eligible individuals statewide to the maximum extent possible.

22.6(1) A provider shall be approved to participate in the autism support program provider network if the provider meets one of the following standards and is approved to provide applied behavior analysis services through Medicaid:

a. The autism service provider is a behavior analyst licensed under Iowa Code chapter 154D; or

b. The autism service provider is a psychologist licensed under Iowa Code chapter 154B; or

c. The autism service provider is a psychiatrist licensed under Iowa Code chapter 148.

22.6(2) The administrator's provider network shall accept the rate established by the department through the department's contract with the administrator as payment in full for the services rendered and will not charge eligible individuals any additional fees for services rendered, except for those eligible individuals who are required to pay a portion of the cost of services due to cost-sharing requirements.

22.6(3) The department is responsible for calculating the cost-sharing amount according to standards established in this chapter.

22.6(4) The autism service provider is responsible for collecting the cost-sharing amount from the eligible individual and will only be reimbursed by the administrator for the balance of the service fee minus the amount of cost sharing.

[**ARC 0260D**, IAB 5/13/26, effective 7/1/26]

441—22.7(225D) Financial management of the program.

22.7(1) The department will:

a. Not take new applications for the program that would cause expenditures of the program to exceed the budgeted amount.

b. Limit expenditure of program funds to services for those individuals determined to be eligible individuals and for related administrative costs.

c. Allocate available funds for eligible individuals' services in a manner that allows for funding for all eligible individuals' services authorized by the administrator without exceeding the department's funding limits.

22.7(2) The administrator shall:

a. Limit annual expenditures for each eligible individual to the amount identified in Iowa Code section 225D.2(2)*"a."*

b. Limit length of service through the program to the amount identified in Iowa Code section 225D.2(2)*"b."*

c. Limit payment for applied behavior analysis services to an hourly or equivalent quarter-hour unit rate that is equal to the contracted rate currently paid by Medicaid for applied behavior analysis services.

d. Not provide financial compensation to RAP for care coordination services.

[**ARC 0260D**, IAB 5/13/26, effective 7/1/26]

441—22.8(225D) Appeal. Notice of adverse action shall be given in accordance with 441—Chapter 16. The right to appeal shall be given in accordance with 441—Chapter 2506.

[**ARC 0260D**, IAB 5/13/26, effective 7/1/26]

These rules are intended to implement Iowa Code chapter 225D.

[Filed ARC 1329C (Notice ARC 1184C, IAB 11/13/13), IAB 2/19/14, effective 4/1/14]
[Filed ARC 2816C (Notice ARC 2680C, IAB 8/17/16), IAB 11/23/16, effective 1/1/17]
[Filed ARC 3057C (Notice ARC 2971C, IAB 3/15/17), IAB 5/10/17, effective 7/1/17]
[Filed ARC 3788C (Notice ARC 3619C, IAB 2/14/18), IAB 5/9/18, effective 7/1/18]
[Filed ARC 6386C (Notice ARC 6299C, IAB 4/20/22), IAB 6/29/22, effective 9/1/22]
[Filed ARC 0260D (Notice ARC 0128D, IAB 3/18/26), IAB 5/13/26, effective 7/1/26]

CHAPTER 23
MENTAL HEALTH AND DISABILITY SERVICES REDESIGN TRANSITION FUND

Rescinded **ARC 4610C**, IAB 8/14/19, effective 9/18/19

CHAPTER 24
ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS, INTELLECTUAL DISABILITIES, OR DEVELOPMENTAL DISABILITIES

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

PREAMBLE

The mental health and disability services commission has adopted this set of standards to be met by all providers of services to people with mental illness, intellectual disabilities, or developmental disabilities. These standards apply to providers that are not required to be licensed by the department of inspections and appeals. These providers include community mental health centers, mental health services providers, case management providers, supported community living providers, and crisis response providers in accordance with Iowa Code chapter 225C.

The standards serve as the foundation of a performance-based review of those organizations for which the department holds accreditation responsibility, as set forth in Iowa Code chapters 225C and 230A. The mission of accreditation is to assure individuals using the services and the general public of organizational accountability for meeting best practices performance levels, for efficient and effective management, and for the provision of quality services that result in quality outcomes for individuals using the services.

The department's intent is to establish standards that are based on the principles of quality improvement and are designed to facilitate the provision of excellent quality services that lead to positive outcomes. The intent of these standards is to make organizations providing services responsible for effecting efficient and effective management and operational systems that enhance the involvement of individuals using the services and to establish a best practices level of performance by which to measure provider organizations.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

DIVISION I
SERVICES FOR INDIVIDUALS WITH DISABILITIES

PREAMBLE

This set of standards in this division has been established to be met by all providers of case management, day treatment, intensive psychiatric rehabilitation, supported community living, partial hospitalization, outpatient counseling and emergency services.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.1(225C) Definitions.

"Accreditation" means the decision made by the division that the organization has met the applicable standards.

"Advanced registered nurse practitioner" means a nurse who has current licensure as a registered nurse in Iowa, or licensure in another state that is recognized in Iowa pursuant to Iowa Code chapter 152E, and who is also registered as certified in psychiatric mental health specialties pursuant to board of nursing rules in 655—Chapter 7.

"Advisory board" means the board that reviews and makes recommendations to the organization on the program being accredited. The advisory board shall meet at least three times a year and shall have at least three members, at least 51 percent of whom are not providers. The advisory board shall include representatives who have disabilities or family members of persons with disabilities. The advisory board's duties include review and recommendation of policies, development and review of the organizational plan for the program being accredited, review and recommendation of the budget for the program being accredited, and review and recommendation of the performance improvement program of the program being accredited.

"Anticipated discharge plan" means the statement of the condition or circumstances by which the individual using the service would no longer need each of the specific services accredited under this chapter.

"Appropriate" means the degree to which the services or supports or activities provided or undertaken by the organization are suitable and desirable for the needs, situation, or problems of the individual using the service.

"Assessment" means the review of the current functioning of the individual using the service in regard to the individual's situation, needs, strengths, abilities, desires and goals.

"Benchmarks" means the processes of an organization that lead to implementation of the indicators.

"Chronic mental illness" means the condition present in people aged 18 and over who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. People with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization).
2. They have experienced at least one episode of continuous, structured, supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, employed in a sheltered setting, or have markedly limited skills and a poor work history.
2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
3. They show severe inability to establish or maintain a personal social support system.
4. They require help in basic living skills.
5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness.

"Commission" means the mental health and disability services commission (MHDS commission) as established and defined in Iowa Code section 225C.5.

"Community" means a natural setting where people live, learn, work, and socialize.

"Community mental health center" or *"CMHC"* means an organization providing mental health services that is established pursuant to Iowa Code chapters 225C and 230A and accredited in accordance with Division III of this chapter.

"Crisis intervention plan" means a personalized, individualized plan developed with the individual using the service that identifies potential personal psychiatric, environmental, and medical emergencies. This plan shall also include those life situations identified as problematic and the identified strategies and natural supports developed with the individual using the service to enable the individual to self-manage, alleviate, or end the crisis. This plan shall also include how the individual can access emergency services that may be needed.

"Deemed status" means acceptance by the division of accreditation or licensure of a program or service by another accrediting body in lieu of accreditation based on review and evaluation by the division.

"Department" means the Iowa department of human services.

"Developmental disability" means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

A person from birth to the age of nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described above if the person, without services and supports, has a high probability of meeting those criteria later in life.

"Direct services" means services providing therapy, habilitation, or rehabilitation activities or support services such as transportation.

"Division" means the division of mental health and disability services, community, of the department of human services.

"Doctor of medicine or osteopathic medicine" means a person who is licensed in the state of Iowa under Iowa Code chapter 148 as a physician and surgeon or under Iowa Code chapter 150A as an osteopathic physician and surgeon.

"Functional assessment" means the analysis of daily living skills. The functional assessment also takes into consideration the strengths, stated needs, and level and kind of disability of the individual using the service.

"Goal achieving" means to gain the required skills and supports to obtain the goal of choice. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Goal keeping" means assisting the individual using the service in maintaining successful and satisfying role performance to prevent the emergence of symptoms associated with role deterioration. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Incident," for the purposes of this chapter, means an occurrence involving the individual using the service that:

1. Results in a physical injury to or by the individual that requires a physician's treatment or admission to a hospital, or
2. Results in someone's death, or
3. Requires emergency mental health treatment for the individual, or
4. Requires the intervention of law enforcement, or
5. Results from any prescription medication error, or
6. Is reportable to protective services.

"Indicators" means conditions that will exist when the activity is done competently and benchmarks are achieved. Indicators also provide a means to assess the activity's effect on outcomes of services.

"Informed consent" refers to time-limited, voluntary consent. The individual using the service or the individual's legal guardian may withdraw consent at any time without risk of punitive action. "Informed consent" includes a description of the treatment and specific procedures to be followed, the intended outcome or anticipated benefits, the rationale for use, the risks of use and nonuse, and the less restrictive alternatives considered. The individual using the service or the legal guardian has the opportunity to ask questions and have them satisfactorily answered.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) under these rules which shall be made only when the onset of the person's condition was during the developmental period and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. A licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills shall make the diagnosis. A diagnosis of intellectual disability shall be made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Intensive psychiatric rehabilitation practitioner" means a person who has at least 60 contact hours of training in intensive psychiatric rehabilitation and either:

1. Is certified as a psychiatric rehabilitation practitioner by the United States Psychiatric Rehabilitation Association; or

2. Holds a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and has at least one year of experience in the delivery of services to the population groups that the person is hired to serve.

"Leadership" means the governing board, the chief administrative officer or executive director, managers, supervisors, and clinical leaders who participate in developing and implementing organizational policies, plans and systems.

"Marital and family therapist" means a person who is licensed under Iowa Code chapter 154D in the application of counseling techniques in the assessment and resolution of emotional conditions. This includes the alteration and establishment of attitudes and patterns of interaction relative to marriage, family life, and interpersonal relationships.

"Mental health counselor" means a person who is licensed under Iowa Code chapter 154D in counseling services involving assessment, referral, consultation, and the application of counseling, human development principles, learning theory, group dynamics, and the etiology of maladjustment and dysfunctional behavior to individuals, families, and groups.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided. Organizations included are:

1. Those contracting with a county board of supervisors to provide mental health services in lieu of that county's affiliation with a community mental health center (Iowa Code chapter 230A).

2. Those that may contract with a county board of supervisors for special services to the general public or special segments of the general public and that are not accredited by any other accrediting body.

These standards do not apply to individual practitioners or partnerships of practitioners covered under Iowa's professional licensure laws.

"Natural supports" means those services and supports an individual using the service identifies as wanted or needed that are provided at no cost by family, friends, neighbors, and others in the community, or by organizations or entities that serve the general public.

"New organization" means an entity that has never been accredited under 441—Chapter 24 or an accredited entity under 441—Chapter 24 that makes a significant change in its ownership, structure, management, or service delivery.

"Organization" means:

1. A governmental entity or an entity that meets Iowa Code requirements for a business organization as a for-profit or not-for-profit business. These entities include, but are not limited to, a business corporation under Iowa Code chapter 490 or a nonprofit corporation under Iowa Code chapter 504 that provides a service accredited pursuant to the rules in this chapter.

2. A county, consortium of counties, or the department of human services that provides or subcontracts for the provision of case management.

3. A division or unit of a larger entity, such as a unit within a hospital or parent organization.

"Organization" does not include: an individual for whom a license to engage in a profession is required under Iowa Code section 147.2, any person providing a service if the person is not organized

as a corporation or other business entity recognized under the Iowa Code, or an entity that provides only financial, administrative, or employment services and that does not directly provide the services accredited under this chapter.

"Outcome" means the result of the performance or nonperformance of a function or process or activity.

"Policies" means the principles and statements of intent of the organization.

"Procedures" means the steps taken to implement the policies of the organization.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for the population of a specified geographic area or for special target populations.

"Psychiatric crisis intervention plan" means a personalized, individualized plan developed with the individual using the service that identifies potential personal psychiatric emergencies. This plan shall also include those life situations identified as problematic and the identified strategies and natural supports developed with the individual using the service to enable the individual to self-manage, alleviate, or end the crisis. This plan shall also include how the individual can access emergency services that may be needed.

"Psychiatric nurse" means a person who meets the requirements of a certified psychiatric nurse, is eligible for certification by the American Nursing Association, and is licensed by the state of Iowa to practice nursing as defined in Iowa Code chapter 152.

"Psychiatrist" means a doctor of medicine or osteopathic medicine who is certified by the American Board of Psychiatry and Neurology or who is eligible for certification and who is fully licensed to practice medicine in the state of Iowa.

"Psychologist" means a person who:

1. Is licensed to practice psychology in the state of Iowa or meets the requirements of eligibility for a license to practice psychology in the state of Iowa as defined in Iowa Code chapter 154B; or

2. Is certified by the Iowa department of education as a school psychologist or is eligible for certification by the Iowa department of education.

"Qualified case managers and supervisors" means people who have the following qualifications:

1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or

2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

People employed as case management supervisors on or before August 1, 1993, who do not meet these requirements shall be considered to meet these requirements as long as they are continuously employed by the same case management provider.

"Readiness assessment" means a process of involving the individual using the service in clarifying motivational readiness to participate in the recovery process. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Readiness development" means services designed to develop or increase an individual's interest, motivation, and resolve to engage in the rehabilitation services process, as a means of enhancing independent functioning and quality of life. For purposes of this chapter, the definition and explanation are taken from the Psychiatric Rehabilitation Practitioner Tools, as developed by the Boston Center for Psychiatric Rehabilitation.

"Registered nurse" means a person who is licensed to practice nursing in the state of Iowa as defined in Iowa Code chapter 152.

"Rehabilitation services" means services designed to restore, improve, or maximize the individual's optimal level of functioning, self-care, self-responsibility, independence and quality of life and to minimize impairments, disabilities and dysfunction caused by a serious and persistent mental or emotional disability.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom the individual using the service may share a residence.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities. "Serious emotional disturbance" shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as "other conditions that may be a focus of clinical attention," unless those conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means an individualized goal-oriented plan of services written in language understandable by the individual using the service and developed collaboratively by the individual and the organization.

"Staff" means people paid by the organization to perform duties and responsibilities defined in the organization's policies and procedures.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.2(225C) Standards for policy and procedures.

24.2(1) *Performance benchmark.* The organization has written policy direction for the organization and each service being accredited.

24.2(2) *Performance indicators.*

a. The organization has a policies and procedures manual with policy guidelines and administrative procedures for all organizational activities and services specific to its organization that addresses the standards in effect at the time of review.

b. The policies and procedures cover each benchmark and indicator in this chapter.

c. The policies and procedures manual is made available to all staff.

441—24.3(225C) Standards for organizational activities.

24.3(1) *Performance improvement system.*

a. Performance benchmark. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance.

b. Performance indicators. The organization:

(1) Annually measures and assesses organizational activities and services accredited in this chapter.

(2) Gathers information from individuals using the services, from staff, and from family members.

(3) Implements an internal review of individual records for those services accredited under this chapter. For outpatient psychotherapy and counseling services, the organization:

1. Reviews the individual's involvement in and with treatment.

2. Ensures that treatment activities are documented and are relevant to the diagnosis or presenting problem.

(4) Reviews the organization's response to incidents reported under subrule 24.4(5) for necessity, appropriateness, effectiveness and prevention. This review includes analysis of incident data at least annually to identify any patterns of risk to the health and safety of consumers.

(5) Reviews the organization's response to any situation that poses a danger or threat to staff or to individuals using the services for necessity, appropriateness, effectiveness, and prevention.

(6) Identifies areas in need of improvement.

(7) Has a plan to address the areas in need of improvement. Where applicable, the organization establishes a plan to resolve the problem of patients missing appointments.

(8) Implements the plan and documents the results.

24.3(2) *Leadership.*

a. Performance benchmark. Organization leaders provide the framework for the planning, designing, directing, coordination, provision and improvement of services that are responsive to the individuals using the services and the community served by the organization.

b. Performance indicators.

(1) There are clearly articulated mission and values statements that are reflected in the long-range organizational plans and in organization policies.

(2) The annual and long-range budgeting process involves appropriate governing and managing levels of leadership and reflects the organization's mission and values. An independent auditor or other person as provided by law performs an annual financial audit. Designated CMHCs shall submit their annual financial audit to the department.

(3) Individuals using the services or family members of individuals using the services are represented on the organization's governing board or on an advisory board.

(4) The organization's decision-making process, including policy decisions affecting the organization, reflects involvement of the various levels of leadership and responsiveness to staff.

(5) Organization leaders solicit input from leaders of the various community groups representing individuals served by the organization in designing responsive service delivery systems.

(6) Organization leaders develop and implement a service system appropriate to the needs of the individuals served by the organization.

(7) Organization leaders make educational information, resources, and service consultation available to community groups.

24.3(3) *Management information system.*

a. Performance benchmark. Information is obtained, managed, and used in an efficient and effective method to document, enhance, and improve organizational performance and service delivery.

b. Performance indicators.

(1) The organization has a system in place to maintain current individual-specific information documenting the provision and outcomes of services and treatments provided.

(2) The organization has a system in place to maintain the confidentiality and security of information that identifies specific individuals using the services, including mail, correspondence, and electronic files.

24.3(4) *Human resources.*

a. Performance benchmark. The organization provides qualified staff to support the organization's mission and facilitate the provision of quality services.

b. Performance indicators. The organization:

(1) Has a job description in the personnel file of each staff member that clearly defines responsibilities and qualifications.

(2) Has a process to verify qualifications of staff, including degrees, licenses, medication management training, and certification as required by the position, within 90 days of the staff person's employment. For staff hired after July 1, 2006, personnel files contain evidence that verification of professional licenses and college degrees at the bachelor's level or higher, as required by the position, was obtained from the primary source.

(3) Evaluates staff annually.

(4) Includes a plan for staff development for each staff member in the annual evaluation.

(5) Provides training and education to all staff relevant to their positions.

(6) Provides for approved training on child and dependent adult abuse reporter requirements to all organization staff who are mandatory abuse reporters. The organization documents in personnel records training on child and dependent adult abuse reporter requirements.

(7) Has staff members sign a document indicating that they are aware of the organization's policy on confidentiality and maintains these documents in the personnel files.

(8) Provides an initial orientation to new staff and documents this orientation in the employee's personnel file.

(9) Has mechanisms in place that afford staff the right to express concerns about a particular care issue or to file a grievance concerning a specific employment situation.

(10) Completes criminal and abuse record checks and evaluations as required in Iowa Code section 135C.33(5) before employment for any employee who meets with individuals using the services in the individuals' homes.

(11) Establishes and implements a code of ethics for all staff addressing confidentiality, individual rights, and professional and legal issues in providing services and documents in the personnel records that the code of ethics in effect at the time of review has been reviewed with each staff member.

24.3(5) *Organizational environment.*

a. Performance benchmark. The organization provides services in an organizational environment that is safe and supportive for the individuals being served and the staff providing services.

b. Performance indicators.

(1) The environment enhances the self-image of the individual using the service and preserves the individual's dignity, privacy, and self-development.

(2) The environment is safe and accessible and meets all applicable local, state, and federal regulations.

(3) The processes that service and maintain the environment and the effectiveness of the environment are reviewed within the organization's monitoring and improvement system.

(4) The organization establishes intervention procedures for behavior that presents significant risk of harm to the individual using the service or others. The interventions also ensure that the individual's rights are protected and that due process is afforded.

(5) The organization meets state and federal regulations in the way it implements the safe storage, provision, administration, and disposal of medication when used within the service.

(6) All toys and other materials used by children are clean and safe.

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.4(225C) Standards for services. Providers for the services set forth in subrules 24.4(9) through 24.4(13) shall meet the standards in subrules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and counseling services shall also meet standards in subrules 24.4(1), 24.4(2), 24.4(4), 24.4(6), 24.4(7), and 24.4(8). Providers of emergency services or evaluation services shall meet the benchmark for the services they provide.

24.4(1) *Social history.*

a. Performance benchmark. The organization completes a social history for each individual served.

b. Performance indicators.

(1) The organization collects and documents relevant historical information and organizes the information in one distinct document.

(2) The social history includes:

1. Relevant information regarding the onset of disability.
2. Family, physical, psychosocial, behavioral, cultural, environmental, and legal history.
3. Developmental history for children.
4. Any history of substance abuse, domestic violence, or physical, emotional, or sexual abuse.

(3) Staff review and update the social history at least annually.

24.4(2) *Assessment.*

a. Performance benchmark. The organization develops a written assessment for each individual served. The assessment is the basis for the services provided to the individuals.

b. Performance indicators.

(1) The assessment includes information about the individual's current situation, diagnosis, needs, problems, wants, abilities and desired results, gathered with the individual's involvement.

(2) Staff solicit collateral provider information as appropriate to the individual situation in order to compile a comprehensive and full assessment.

(3) Staff base decisions regarding the level, type and immediacy of services to be provided, or the need for further assessment or evaluation, upon the analysis of the information gathered in the assessment.

(4) Staff complete an annual reassessment for each individual using the service and document the reassessment.

(5) Documentation supporting the diagnosis is contained in the individual's record. A diagnosis of intellectual disability is supported by a psychological evaluation conducted by a qualified professional. A diagnosis of developmental disability is supported by professional documentation. A determination of chronic mental illness is supported by a psychiatric or psychological evaluation conducted by a qualified professional.

24.4(3) *Individual service plan.*

a. Performance benchmark. Individualized, planned, and appropriate services are guided by an individual-specific service plan developed in collaboration with the individual using the service, staff, and significantly involved others as appropriate. Services are planned for and directed to where the individuals live, learn, work, and socialize.

b. Performance indicators.

(1) The service plan is based on the current assessment.

(2) The service plan identifies observable or measurable individual goals and action steps to meet the goals.

(3) The service plan includes interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(4) The service plan includes the staff, people, or organizations responsible for carrying out the interventions or supports.

(5) Services defined in the service plan are appropriate to the severity level of problems and specific needs or disabilities.

(6) The plan reflects desired individual outcomes.

(7) Activities identified in the service plan encourage the ability and right of the individual using the service to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) Staff monitor the service plan with review occurring regularly. At least annually, staff assess and revise the service plan to determine achievement, continued need, or change in goals or intervention methods. The review includes the individual using the service, with the involvement of significant others as appropriate.

(9) Staff develop a separate, individualized, anticipated discharge plan as part of the service plan that is specific to each service the individual receives.

(10) The service plan includes documentation of any rights restrictions, why there is a need for the restriction, and a plan to restore those rights or a reason why a plan is not necessary or appropriate.

24.4(4) *Documentation of service provision.*

a. Performance benchmark. Individualized and appropriate intervention services and treatments are provided in ways that support the needs, desires, and goals identified in the service plan, and that respect the rights and choices of the individual using the service.

b. Performance indicators.

(1) Staff document in the narrative the individual's participation in the treatment process.

(2) Responsible staff document the individual's progress toward goals, the provision of staff intervention, and the individual's response to those interventions.

(3) Documentation of service provision is in a legible, written format in accordance with organizational policies and procedures.

24.4(5) *Incident reports.*

a. Performance benchmark. The organization completes an incident report when organization staff first become aware that an incident has occurred.

b. Performance indicators.

(1) The organization documents the following information:

1. The name of the individual served who was involved in the incident.
2. The date and time the incident occurred.
3. A description of the incident.

4. The names of all organization staff and others who were present or responded at the time of the incident. (For confidentiality reasons, other individuals who receive services should be identified by initials or some other accepted means.)

5. The action the organization staff took to handle the situation.

6. The resolution of or follow-up to the incident.

(2) The staff who were directly involved at the time of the incident or who first became aware of the incident prepare and sign the incident report before forwarding it to the supervisor.

(3) Staff file a copy of the completed incident report in a centralized location and make a notation in the individual's file.

(4) Staff send a copy of the incident report to the individual's Medicaid targeted case manager or county case worker who is involved in funding the service and notify the individual's legal guardian within 72 hours of the incident.

24.4(6) *Confidentiality and legal status.*

a. Performance benchmark. Staff release medical and mental health information only when properly authorized.

b. Performance indicators.

(1) The organization obtains voluntary written authorization from the individual using the service, the individual's legal guardian, or other people authorized by law before releasing personal identifying information, medical records, mental health records, or any other confidential information.

(2) Staff complete voluntary written authorization forms in accordance with existing federal and state laws, rules, and regulations and maintain them in each individual file.

(3) Documentation regarding restrictions on the individual, such as guardianship, power of attorney, conservatorship, mental health commitments, or other court orders, is placed in the individual's record, if applicable.

24.4(7) *Service systems.*

a. Performance benchmark. The organization develops a clear description of each of the services offered. The organization develops an admission and discharge system of services. Staff coordinate services with other settings and providers.

b. Performance indicators.

(1) The organization has established and documented the necessary admission information to determine each individual's eligibility for participation in the service.

(2) Staff include verification in each individual's file that a service description was provided to the individual using the service and, when appropriate, to family or significant others.

(3) Continuity of services occurs through coordination among the staff and professionals providing services. Coordination of services through linkages with other settings and providers has occurred, as appropriate.

(4) Staff include a written discharge summary in each individual record at the time of discharge.

24.4(8) *Respect for individual rights.*

a. Performance benchmark. Each individual using the service is recognized and respected in the provision of services, in accordance with basic human, civil, and statutory rights.

b. Performance indicators.

(1) Staff provide services in ways that respect and enhance the individual's sense of autonomy, privacy, dignity, self-esteem, and involvement in the individual's own treatment. Staff take language barriers, cultural differences, and cognitive deficits into consideration and make provisions to facilitate meaningful individual participation.

(2) Staff inform individuals using the service and, when appropriate, family and significant others of their rights, choices, and responsibilities.

(3) The organization has a procedure established to protect the individuals using the service during any activities, procedure or research that requires informed consent.

(4) The organization verifies that individuals using the service and their guardians are informed of the process to express questions, concerns, complaints, or grievances about any aspect of the individual's service, including the appeal process.

(5) The organization provides the individuals and their guardians the right to appeal the application of policies, procedures, or any staff action that affects the individual using the service. The organization has established written appeal procedures and a method to ensure that the procedures and appeal process are available to individuals using the service.

(6) All individuals using the service, their legal representatives, and other people authorized by law have access to the records of the individual using the service in accordance with state and federal laws and regulations.

24.4(9) *Case management services.* "Case management services" means those services established pursuant to Iowa Code section 225C.20.

a. Performance benchmark. Case management services link individuals using the service to service agencies and support systems responsible for providing the necessary direct service activities and coordinate and monitor those services.

b. Performance indicators.

(1) Staff clearly define the need for case management and document it annually.

(2) At a minimum, the team is composed of the individual using the service, the case manager, and providers or natural supports relevant to the individual's service needs. The team may also include family members, at the discretion of the individual using the service.

(3) The team works with the individual using the service to establish the service plan that guides and coordinates the delivery of the services.

(4) The case manager advocates for the individual using the service.

(5) The case manager coordinates and monitors the services provided to the individual using the service.

(6) Documentation of contacts includes the date, the name of the individual using the service, the name of the case manager, and the place of service.

(7) The case manager holds individual face-to-face meetings at least quarterly with the individual using the service.

(8) Case managers do not provide direct services. Individuals using the service are linked to appropriate resources, which provide necessary direct services and natural supports.

(9) Individuals using the service participate in developing an individualized crisis intervention plan that includes natural supports and self-help methods.

(10) Documentation shows that individuals using the service are informed about their choice of providers as provided in the county management plan.

(11) Within an accredited case management program, the average caseload is no more than 45 individuals per each full-time case manager. The average caseload of children with serious emotional disturbance is no more than 15 children per full-time case manager.

(12) The case manager communicates with the team and then documents in the individual's file a quarterly review of the individual's progress toward achieving the goals.

24.4(10) *Day treatment services.* "Day treatment" means an individualized service emphasizing mental health treatment and intensive psychosocial rehabilitation activities designed to increase the individual's ability to function independently or facilitate transition from residential placement. Staff use individual and group treatment and rehabilitation services based on individual needs and identified behavioral or mental health issues.

a. Performance benchmark. Individuals using the service who are experiencing a significantly reduced ability to function in the community are stabilized and improved by the receipt of psychosocial rehabilitation, mental health treatment services, and in-home support services, and the need for residential or inpatient placement is alleviated.

b. Performance indicators.

(1) Individuals using the service participate with the organizational staff in identifying the problem areas to be addressed and the goals to be achieved that are based on the individual's need for services.

(2) Individuals using the service receive individualized services designed to focus on those identified mental health or behavioral issues that are causing significant impairment in their day-to-day functioning.

(3) Individuals who receive intensive outpatient and day treatment services receive a comprehensive and integrated schedule of recognized individual and group treatment and rehabilitation services.

(4) Individuals using the service and staff review their progress in resolving problems and achieving goals on a frequent and regular basis.

(5) Individuals using the service receive services appropriate to defined needs and current risk factors.

(6) Individuals using the service receive services from staff who are appropriately qualified and trained to provide the range and intensity of services required by the individual's specific problems or disabilities. A mental health professional provides or directly supervises the provision of treatment services.

(7) Individuals using the service participate in discharge planning that focuses on coordinating and integrating individual, family, and community and organization resources.

(8) Family members of individuals using the service are involved in the planning and provision of services, as appropriate and as desired by the individual.

(9) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

24.4(11) *Intensive psychiatric rehabilitation services.* "Intensive psychiatric rehabilitation services" means services designed to restore, improve, or maximize level of functioning, self-care, responsibility, independence, and quality of life; to minimize impairments, disabilities, and disadvantages of people who have a disabling mental illness; and to prevent or reduce the need for services in a hospital or residential setting. Services focus on improving personal capabilities while reducing the harmful effects of psychiatric disability, resulting in an individual's recovering the ability to perform a valued role in society.

a. Performance benchmark. Individuals using the service who are experiencing a significantly reduced ability to function in the community due to a disability are stabilized and experience role recovery by the receipt of intensive psychiatric rehabilitation services.

b. Performance indicators.

(1) Individuals using the service receive services from staff who meet the definition of intensive psychiatric rehabilitation practitioner. The intensive psychiatric rehabilitation supervisor has at least a bachelor's degree in a human services field and 60 hours of training in intensive psychiatric rehabilitation.

(2) Individuals using the service receive four to ten hours per week of recognized psychiatric rehabilitation services. All services are provided for an identified period.

(3) Whenever possible, intensive psychiatric rehabilitative services are provided in natural settings where individuals using the service live, learn, work, and socialize.

(4) Significantly involved others participate in the planning and provision of services as appropriate and as desired by the individual using the service.

(5) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

(6) A readiness assessment is initially completed with staff to assist the individual in choosing a valued role and environment. The readiness assessment culminates in a score that documents the individual's motivational readiness.

(7) During the readiness development phase, staff document monthly in the individual's file changes in the individual's motivational readiness to choose valued roles and environments.

(8) During the goal-choosing phase, staff and the individual identify personal criteria, describe alternative environments, and choose the goal. These activities are documented in the individual's file.

(9) During the goal-achieving phase, the functional assessment and resource assessment are completed. Skill programming or skill teaching takes place. These activities are documented in the individual's file.

(10) During goal keeping, individuals using the service participate in discharge planning that focuses on coordinating and integrating individual, family, community, and organization resources for successful community tenure and the anticipated end of psychiatric rehabilitation services. Staff document increases in skill acquisition and skill competency.

(11) Staff document any positive changes in environmental status, such as moving to a more independent living arrangement, enrolling in an education program, getting a job, or joining a community group.

(12) On an ongoing basis and at discharge, staff or the individual using the service documents the level of individual satisfaction with intensive psychiatric rehabilitation services in each individual's file.

24.4(12) *Supported community living services.* "Supported community living services" means those services provided to individuals with a mental illness, mental retardation, or developmental disability to enable them to develop supports and learn skills that will allow them to live, learn, work and socialize in the community. Services are individualized, need- and abilities-focused, and organized according to the following components: outreach to appropriate support or treatment services; assistance and referral in meeting basic human needs; assistance in housing and living arrangements; crisis intervention and assistance; social and vocational assistance; the provision of or arrangement for personal, environmental, family, and community supports; facilitation of the individual's identification and development of natural support systems; support, assistance, and education to the individual's family and to the community; protection and advocacy; and service coordination.

These services are to be provided by organizational staff or through linkages with other resources and are intended to be provided in the individual's home or other natural community environment where the skills are learned or used. Supported community living is not part of an organized mental health support or treatment group, drop-in center, or clubhouse. Skill training groups may be one of the activities in the service plan and part of supported community living. Skill training groups cannot stand alone as a supported community living service.

a. Performance benchmark. Individuals using the service live, learn, work, and socialize in the community.

b. Performance indicators.

(1) Individuals receive services within their home and community setting where the skills are learned or used.

(2) At intake, the individuals using the service participate in a functional assessment to assist in defining areas of service need and establishing a service plan. Staff summarize the findings of the functional assessment in a narrative that describes the individual's current level of functioning in the areas of living, learning, working, and socialization. Staff review functional assessments on a regular basis to determine progress.

(3) Individuals using the service receive skill training and support services directed to enabling them to regain or attain higher levels of functioning or to maximize functioning in the current goal areas.

(4) Services are delivered on an individualized basis in the place where the individual using the service lives or works.

(5) Documentation that steps have been taken to encourage the use of natural supports and develop new ones is in the individual file.

(6) Individuals using the service participate in developing a detailed individualized crisis intervention plan that includes natural supports and self-help methods.

24.4(13) *Partial hospitalization services.* "Partial hospitalization services" means an active treatment program providing intensive group and individual clinical services within a structured therapeutic environment for individuals who are exhibiting psychiatric symptoms of sufficient severity to cause significant impairment in day-to-day functioning. Short-term outpatient crisis stabilization and rehabilitation services are provided to avert hospitalization or to transition from an acute care setting. Services are supervised and managed by a mental health professional, and psychiatric consultation is routinely available. Clinical services are provided by a mental health professional.

a. Performance benchmark. Individuals who are experiencing serious impairment in day-to-day functioning due to severe psychiatric distress are enabled to remain in their community living situation through the receipt of therapeutically intensive milieu services.

b. Performance indicators.

(1) Individuals using the service and staff mutually develop an individualized service plan that focuses on the behavioral and mental health issues and problems identified at admission. Goals are based on the individual's need for services.

(2) Individuals using the service receive clinical services that are provided and supervised by mental health professionals. A licensed and qualified psychiatrist provides psychiatric consultation and medication services.

(3) Individuals using the service receive a comprehensive schedule of active, planned, and integrated psychotherapeutic and rehabilitation services provided by qualified professional staff.

(4) Individuals using the service receive group and individual treatment services that are designed to increase their ability to function independently.

(5) Individuals using the service are involved in the development of an anticipated discharge plan that includes linkages to family, provider, and community resources and services.

(6) Individuals using the service have sufficient staff available to ensure their safety, to be responsive to crisis or individual need, and to provide active treatment services.

(7) Individuals using the service receive services commensurate with current identified risk and need factors.

(8) Support systems identified by individuals using the service are involved in the planning and provision of services and treatments as appropriate and desired by the individual using the service.

(9) Individuals using the service participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

24.4(14) *Outpatient psychotherapy and counseling services.* "Outpatient psychotherapy and counseling services" means a dynamic process in which the therapist uses professional skills, knowledge and training to enable individuals using the service to realize and mobilize their strengths and abilities, take charge of their lives, and resolve their issues and problems. Psychotherapy services may be individual, group, or family, and are provided by a person meeting the criteria of a mental health professional or by a person with a master's degree or an intern working on a master's degree in a mental health field who is directly supervised by a mental health professional.

a. Performance benchmark. Individuals using the service realize and mobilize their own strengths and abilities to take control of their lives in the areas where they live, learn, work, and socialize.

b. Performance indicators.

(1) Individuals using the service are prepared for their role as partners in the therapeutic process at intake where they define their situations and evaluate those factors that affect their situations.

(2) Individuals using the service establish desired problem resolution at intake during the initial assessment.

(3) Psychiatric services other than psychopharmacological services are available from the organization as needed by the individual using the service.

(4) Psychopharmacological services are available from the organization as needed.

(5) Any assignment of activities to occur between sessions is documented in the following session's documentation.

(6) Individuals using the service who have a chronic mental illness participate in developing a detailed psychiatric crisis intervention plan that includes natural supports and self-help methods.

(7) The record documents that the organization follows up on individuals who miss appointments.

(8) Treatment planning is based on the assessment.

(9) Individuals using the service participate with the organizational staff in identifying the assessed needs to be addressed.

(10) The treatment plan identifies measurable goals, desired outcomes and time frames for achieving them.

(11) The treatment plan includes interventions and supports to be provided.

(12) Individuals using the service review their progress in resolving problems and achieving goals on a frequent and regular basis with organizational staff. The treatment plan is revised as appropriate to the individual's needs and priorities.

(13) Individuals using the service participate in transition/discharge planning that includes linkages to family, provider, and community resources and services.

(14) Significantly involved others of individuals using the service are involved in the planning and provision of services, as appropriate and as desired by the individual.

24.4(15) *Emergency services.* "Emergency services" means crisis services that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress and are available and accessible, by telephone or face-to-face, on a 24-hour basis. The clinical assessment and psychotherapeutic services are provided by a person who has training in emergency services and who is a mental health professional or has access to a mental health professional, at least by telephone.

Services may be provided by a person who holds a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing, psychiatric rehabilitation, or social work; or a person who holds a bachelor's degree in a human service discipline with five years' experience providing mental health services or human services; or a psychiatric nurse who has three years of clinical experience in mental health. A comprehensive social history is not required for this treatment.

a. Performance benchmark. Individuals using the service receive emergency services when needed that provide a focused assessment and rapid stabilization of acute symptoms of mental illness or emotional distress.

b. Performance indicators.

(1) Individuals using the service can access 24-hour emergency services by telephone or in person.

(2) Information about how to access emergency services is publicized to facilitate availability of services to individuals using the service, family members, and the public.

(3) Individuals using the service receive assessments and services from either a mental health professional or from personnel who meet the requirements above and are supervised by a mental health professional. Psychiatric consultation is available, if needed.

(4) Individuals using the service receive intervention commensurate with current identified risk factors.

(5) Significantly involved others are involved as necessary and appropriate to the situation and as desired by the individual using the service.

(6) Individuals using the service are involved in the development of postemergency service planning and resource identification and coordination.

(7) Staff document contacts in a narrative format and maintain them in a central location that will allow timely response to the problems presented by the individual using the service.

(8) Timely coordination of contacts with relevant professionals is made.

24.4(16) *Evaluation services.* "Evaluation services" means screening, diagnosis and assessment of individual and family functioning needs, abilities, and disabilities, and determining current status and functioning in the areas of living, learning, working, and socializing.

a. Performance benchmark. Individuals using the service receive comprehensive evaluation services that include screening, diagnosis, and assessment of individual or family functioning, needs and disabilities.

b. Performance indicators.

(1) Evaluations include screening, diagnosis, and assessment of individual or family functioning, needs, abilities, and disabilities.

(2) Evaluations consider the emotional, behavioral, cognitive, psychosocial, and physical information as appropriate and necessary.

(3) Evaluations includes recommendations for services and need for further evaluations.

(4) Mental health evaluations are completed by a person who meets the criteria of a mental health professional, or a person with a master's degree who is license-eligible and supervised by a mental health professional, or an intern of a master's or doctorate program who is supervised by a mental health professional.

[**ARC 3855C**, IAB 6/20/18, effective 8/1/18; **ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.5(225C) Accreditation. The division administrator shall make all decisions involving issuance, denial, or revocation of accreditation. This accreditation shall delineate all categories of service the

organization is accredited to provide. Although an organization may have more than one facility or service site, the division administrator shall issue only one accreditation notice to the organization, except as provided in paragraph 24.5(5)*"f."*

24.5(1) *Organizations eligible for accreditation.* The division administrator accredits the following organizations:

a. Case management providers.

b. Community mental health centers.

c. Supported community living providers.

d. Mental health service providers.

e. Crisis response providers.

24.5(2) *Application and renewal procedures.* An applicant for accreditation shall submit Form 470-3005, Application for Accreditation, to the Division of Mental Health and Disability Services, Community, Department of Human Services, Fifth Floor, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

a. The application shall be signed by the organization's chief executive officer and the chairperson of the governing body and shall include the following information:

(1) The name and address of the applicant organization.

(2) The name and address of the chief executive officer of the applicant organization.

(3) The type of organization and specific services for which the organization is applying for accreditation.

(4) The targeted population groups for which services are to be provided, as applicable.

(5) The number of individuals in each of the targeted population groups to be served, as applicable.

(6) Other information related to the standards as requested by division staff.

b. Organizations that have received an initial 270-day accreditation and have not provided services by the end of the 270 days shall have their accreditation lapse for that specific service. This lapse of accreditation shall not be considered a denial. New applications may be submitted that include the waiting list of individuals to be served along with specific timelines of when the services will begin.

c. An organization in good standing may apply for an add-on service.

24.5(3) *Application review.* Upon receipt of an application, Form 470-3005, the division shall review the materials submitted to determine whether the application is complete and request any additional material as needed. Survey reviews shall commence only after the organization has submitted all application material.

a. For a new organization, staff may initially conduct a desk audit or on-site visit to review the organization's mission, policies, procedures, staff credentials, and program descriptions.

b. The division shall review organizational services and activities as determined by the accreditation category. This review may include audits of case records, administrative procedures, clinical practices, personnel records, performance improvement systems and documentation, and interviews with staff, individuals, boards of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

c. A team shall make an on-site visit to the organization. The division shall not be required to provide advance notice to the provider of the on-site visit for accreditation.

d. The on-site team shall consist of designated members of the division staff. At the division's discretion, the team may include provider staff of other providers, individuals, and others deemed appropriate.

e. The team shall survey the organization and the services indicated on the accreditation application in order to verify information contained in the application and ensure compliance with all applicable laws, rules, and regulations. At the time of a one-year recertification visit, the team shall review the services that did not receive three-year accreditation.

f. The team shall review case records and personnel records to see how the organization implements each of the indicators in the standards. If the documentation is not found in the records, the organization shall show, at the time the division staff is on site, documentation of how the indicator was accomplished.

g. When an organization subcontracts with agencies to provide services, on-site reviews shall be done at each subcontracting agency to determine if each agency meets all the requirements in this chapter. The accreditation is issued to the organization.

h. At the end of the survey, the team leader shall lend an exit review. Before the close of the on-site review, the organization must provide the team leader any documentation that demonstrates how the organization has met these standards for services.

i. The accreditation team leader shall send a written report of the findings to the organization within 30 working days after completion of the accreditation survey.

j. Organizations required to develop a corrective action and improvement plan pursuant to subrule 24.5(4)*"a"* shall submit the plan to the division within 30 working days after the receipt of a report issued as a result of the division's survey review. The action plan shall include specific problem areas cited, corrective actions to be implemented by the organization, dates by which each corrective measure shall be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

k. Quality assurance staff shall review and approve the corrective action and improvement plan before making an accreditation recommendation to the division administrator.

l. The division shall offer technical assistance to organizations applying for first-time accreditation. Following accreditation, any organization may request technical assistance from the division to bring into conformity those areas found in noncompliance with this chapter's requirements. If multiple deficiencies are noted during a survey, technical assistance may be provided to an organization, as staff time permits, to assist in implementation of an organization's corrective action plan. Renewal applicants may be provided technical assistance as needed, if staff time permits.

24.5(4) *Performance outcome determinations.* There are three major areas addressed in these standards: policies and procedures, organizational activities, and services, as set forth in rules 441—24.2(225C), 441—24.3(225C), and 441—24.4(225C). Each rule contains standards, with a performance benchmark and performance indicators for each standard. Each of the applicable standards for the three areas (policy and procedures, organizational activities, and services) shall be reviewed.

a. Quality assurance staff shall determine a performance compliance level based on the number of indicators found to be in compliance.

(1) For service indicators, if 25 percent or more of the files reviewed do not comply with the requirements for a performance indicator, then that indicator is considered out of compliance and corrective action is required.

(2) Corrective action is required when any indicator under policies and procedures or organizational activities is not met.

b. In the overall rating, the performance rating for policy and procedures shall count as 15 percent of the total, organizational activities as 15 percent of the total, and services as 70 percent of the total.

(1) Each of the three indicators for policy and procedures has a value of 5 out of a possible score of 15.

(2) Each of the 34 indicators for organizational activities has a value of .44 out of a possible score of 15.

(3) Each service has a separate weighting according to the total number of indicators applicable for that service, with a possible score of 70, as follows:

Service	Number of indicators	Value of each indicator
Case management	50	1.4
Day treatment	47	1.49
Intensive psychiatric rehabilitation	50	1.4
Supported community living	44	1.59
Partial hospitalization	47	1.49
Outpatient psychotherapy and counseling	38	1.84
Emergency	8	8.75
Evaluation	4	17.50

c. Quality assurance staff shall determine a separate score for each service to be accredited. When an organization offers more than one service under this chapter, there shall be one accreditation award for all the services based upon the lowest score of the services surveyed.

24.5(5) *Accreditation decisions.* The division shall prepare all documents with a final recommendation regarding accreditation to the division administrator.

If the division administrator approves accreditation, Form 470-3006, Notice of Action-Approval, shall be issued which states the duration of the accreditation and the services that the organization is accredited to provide. If the division administrator denies or revokes accreditation, Form 470-3008, Notice of Action-Denial, shall be issued which states the reasons for the denial.

a. Initial 270-day accreditation. This type of accreditation may be granted to a new organization. The division administrator shall base the accreditation decision on a report by the division that:

(1) The organization has an approved policies and procedures manual that includes job descriptions.

(2) Staff assigned to the positions meet the qualifications in the standards and the policies and procedures of the organization.

b. Three-year accreditation. An organization or service is eligible for this type of accreditation if it has achieved an 80 percent or higher performance compliance level. The organization may be required to develop and submit a plan of corrective action and improvement that may be monitored either by written report or an on-site review.

c. One-year accreditation. An organization is eligible for this type of accreditation when multiple and substantial deficiencies exist in specific areas causing compliance levels with performance benchmarks and indicators to fall between 70 percent and 79 percent, or when previously required corrective action plans have not been implemented or completed. The organization must submit a corrective action plan to correct and improve specific deficiencies and overall levels of functioning. Quality assurance staff shall monitor this plan through on-site reviews, written reports and the provision of technical assistance.

d. Probational 180-day accreditation. An organization is eligible for probational 180-day accreditation instead of denial when the overall compliance level is from 60 to 69 percent, and pervasive and serious deficiencies exist; or when corrective action plans previously required as a result of a one-year accreditation have not been implemented or completed. The division administrator may downgrade organizations with a one-year or three-year accreditation to the probational 180-day accreditation when one or more complaints are founded.

All deficiencies must be corrected by the time of the follow-up on-site survey at the conclusion of the provisional period. After this survey, the organization shall meet the standards for accreditation for a one-year accreditation, or the division administrator shall deny accreditation.

e. Add-on service accreditation. When the on-site review of the add-on service results in a score comparable to the overall organization's score at the time of the most recent accreditation, the organization shall have the add-on accreditation date coincide with the overall accreditation date of the organization. If the add-on service on-site review results in a lower score and lower accreditation decision, division staff shall conduct another on-site review for that add-on service when the add-on service accreditation expires.

f. Special terms.

(1) When an organization subcontracts with more than one agency, the length of accreditation shall be determined individually.

(2) The accreditation period for services that have deemed status according to rule 441—24.6(225C) shall coincide with the period awarded by the national accrediting body or the certification for home- and community-based services.

(3) New or add-on services that meet the requirements for accreditation shall receive an initial 270-day accreditation for that individual service. The term of accreditation shall be determined individually. At the time of recertification of the new add-on service, recommendation may be made to coincide with the term of accreditation for the other services of that organization that are accredited by the division administrator.

(4) An organization must notify the division when there are changes in its ownership, structure, management, or service delivery.

g. Extensions. The division may grant an extension to the period of accreditation if there has been a delay in the accreditation process that is beyond the control of the organization or the division, or the organization has requested an extension to permit the organization to prepare and obtain approval of a corrective action plan. The division shall establish the length of the extension on a case-by-case basis.

h. Denial of accreditation or revocation.

(1) Accreditation shall be denied when there are pervasive and serious deficiencies that put individuals at immediate risk or when the overall compliance level falls to 59 percent or below. Under such circumstances no corrective action report shall be required.

(2) When one or more complaints are received, quality assurance staff shall complete an investigation and submit a report to the division administrator. If any of the complaints are substantiated and the division administrator determines that there is a pervasive or serious deficiency, the division administrator may deny accreditation.

(3) An organization whose accreditation has been denied or revoked shall not be approved for any service for at least six months from the notice of decision denying or revoking accreditation.

(4) If the organization disagrees with any action or failure to act in regard to the notice of decision to deny accreditation to the organization, the organization has the right to appeal in accordance with 441—Chapter 7.

24.5(6) *Nonassignability.* Accreditation shall not be assignable to any other organization or provider. Any person or other legal entity acquiring an accredited facility for the purpose of operating a service shall make an application as provided in subrule 24.5(2) for a new certificate of accreditation. Similarly, any organization having acquired accreditation and desiring to alter the service philosophy or transfer operations to different premises must notify the division in writing 30 calendar days before taking action in order for the division to review the change.

24.5(7) *Discontinuation.*

a. Discontinued organization. A discontinued organization is one that has terminated all of the services for which it has been accredited. Accreditation is not transferable between organizations.

(1) An organization shall notify the division in writing of any sale, change in business status, closure, or transfer of ownership of the business at least 30 calendar days before the action.

(2) The organization shall be responsible for the referral and placement of individuals using the services, as appropriate, and for the preservation of all records.

b. Discontinued service. An organization shall notify the division in writing of the discontinuation of an accredited or certified service at least 30 calendar days before the service is discontinued.

(1) Notice of discontinuation of a service shall not be initiated during the 30 days before the start of a survey. Once a survey has begun, all services shall be considered in determining the organization's accreditation score.

(2) The organization shall be responsible for the referral and placement of individuals using the services, as appropriate, and for the preservation of all records.

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.6(225C) Deemed status (all services). The division shall grant deemed status to organizations accredited by a recognized national, not-for-profit, accrediting body when the division determines the accreditation is for similar services. The division may also grant deemed status for supported community living services to organizations that are certified under the Medicaid home- and community-based services (HCBS) intellectual disability waiver.

24.6(1) *National accrediting bodies.*

a. The national accrediting bodies currently recognized as meeting division criteria for possible deeming are:

(1) The Joint Commission (TJC).

(2) The Commission on Accreditation of Rehabilitation Facilities (CARF).

(3) The Council on Quality and Leadership (The Council).

(4) The Council on Accreditation (COA).

b. The accreditation credentials of these national bodies must specify the type of organization, programs, and services that these bodies accredit and include targeted population groups, if appropriate.

c. Deemed status means that the division is accepting an outside body's review, assessment, and accreditation of an organization's functioning and services. Therefore, the accrediting body doing the review must be assessing categories of organizations and types of programs and services corresponding to those described under this chapter. An organization that has deemed status must adhere to and be accountable for the rules in this chapter.

d. When an organization that is nationally accredited requests deemed status for services not covered by the national body's standards but covered under this chapter, the division shall accredit those services. Division staff shall provide technical assistance to organizations with deemed status.

24.6(2) *Application for deemed status.*

a. To apply for deemed status, the organization shall submit Form 470-3332, Application and Letter of Agreement; copy of the latest survey report; documentation related to any corrective action required; accreditation certificate; documentation of specific programming policies and procedures for populations being served; and credentials for staff providing services to populations served.

b. The division shall not accept an application for deemed status once the division has begun an on-site visit. The organization shall complete the accreditation process.

24.6(3) *Requirements for deemed status.* To be eligible for deemed status, the organization shall:

a. Be currently accredited:

(1) By a recognized national accrediting body for services as defined in subrule 24.6(1); or

(2) For supported community living under the Medicaid HCBS intellectual disability waiver pursuant to 441—subrule 77.37(14). If individuals with mental illness are served, the organization must submit verification of the training and experience of the staff to show that its staff can meet the needs of the individuals served.

b. Require staff for the program being deemed to have the necessary training and experience to meet the needs of the population served.

c. Require staff to meet the incident reporting requirements in subrule 24.4(5).

24.6(4) *Granting of deemed status.* When the division grants deemed status, the accreditation period shall coincide with the period awarded by the national accrediting body or the certification for home- and community-based services. However, under no circumstances shall the division award accreditation for longer than five years.

24.6(5) *Reservations.* When deemed status is granted, the division reserves rights to the following:

a. To have division staff conduct on-site reviews for those organizations applying for deemed status which the division has not previously accredited.

b. To have division staff do joint site visits with the accrediting body, attend exit conferences, or conduct focused follow-behind visits as determined to be appropriate in consultation with the national accrediting organization and the provider organization.

c. To be informed of and to investigate all complaints that fall under this chapter's jurisdiction according to the process in rule 441—24.7(225C). The division shall report findings to the national accrediting body.

d. To review and act upon deemed status when:

(1) Complaints have been founded, or

(2) The organization's national accreditation status expires without renewal, or

(3) The national accrediting body downgrades or withdraws the organization's status.

24.6(6) *Continuation of deemed status.*

a. The organization shall send a copy of Form 470-3332, Application and Letter of Agreement, along with a copy of the application for renewal to the national accrediting body at the same time as application is made to a national accrediting body.

b. HCBS staff shall furnish to the division copies of the letter notifying a provider of a forthcoming recertification for organizations deemed for supported community living under the HCBS intellectual disability waiver.

c. Following the on-site review by a national accrediting body, the organization shall send the division a copy of the cover sheet and the national accrediting body report within 30 calendar days from the

date that the organization receives the documents. If a corrective action plan is required, the organization shall send the division a copy of all correspondence and documentation related to the corrective action.

d. HCBS staff shall furnish the division with copies of HCBS certification reports and any corrective action required by HCBS within 30 calendar days after HCBS staff complete the report or the organization completes required corrective action.

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.7(225C) Complaint process (all services). The division shall receive and record complaints by individuals using the services, employees, any interested people, and the public relating to or alleging violations of applicable requirements of the Iowa Code or administrative rules.

24.7(1) *Submittal of complaint.* The complaint may be submitted in person; or by mail to the Division of Mental Health and Disability Services, Community, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut, Des Moines, Iowa 50319-0114; electronically through the department's website; by email to division staff; or by telephone.

a. The division shall assist individuals in making a complaint as needed or requested.

b. The information received should specifically state the basis of the complaint. The division shall keep the name of the complainant confidential to the extent allowed by law.

24.7(2) *Review of complaint.* Upon receipt of a complaint, the division shall make a preliminary desk review of the complaint to determine an appropriate response. That response may include notifying the person who submitted the complaint that there is no basis for a review, referring the complaint to another investigative body, or making a determination to do a full investigation. The complainant may submit a written request for a report of the findings and actions taken by the division as a result of the complaint.

24.7(3) *Investigation of complaint.* If the division concludes that the complaint is reasonable, has merit, and is based on a violation of rules in this chapter, it may make an investigation of the organization. The division may investigate complaints by an office desk audit or by an on-site investigation. The division shall give priority for on-site investigations to instances when individuals using the service are in immediate jeopardy.

a. If a decision is made to conduct an on-site investigation, the on-site review does not require advance notice to the organization. The division shall notify the chief executive officer and board chairperson of the organization involved before or at the commencement of the on-site investigation that the division has received a complaint.

b. The division shall give the organization an opportunity to informally present a position regarding allegations in the complaint. The organization may submit the position in writing within five working days following the on-site visit or present it in a personal conference with division staff.

c. The division shall submit a written report by certified mail to the chief executive officer of the organization and the chairperson of the board of directors within 20 working days after completion of the investigation.

d. The report shall indicate whether the complaint was or was not substantiated, the basis for the substantiation or nonsubstantiation decision and the specific rules violated, and a recommendation for corrective action with time lines specified in the report.

e. If the complaint is substantiated, the division may take actions deemed appropriate, which may include requiring a corrective action plan, shortening the term of accreditation or suspending or revoking an organization's accreditation, depending on the severity of the substantiated complaint.

f. When the division suspends, shortens or revokes an organization's accreditation as the result of a substantiated compliant, the organization will be notified by certified mail of the findings and actions taken by the division.

g. The date of delivery shown by the certified mail stub shall constitute the date of official notice.

24.7(4) *Corrective action plan.* When the division acts to suspend or revoke accreditation, there will be no corrective action plan. In other instances, if the complaint is substantiated, the organization shall submit a corrective action plan to the division within 20 calendar days after receiving the division's decision. This plan must respond to violations cited and the division's requirements and include time lines, internal monitoring systems, and performance improvement planning.

Failure of the organization to respond within 20 calendar days with an acceptable corrective action plan that addresses the organization's plan of correction following a substantiated investigation or complaint may of itself constitute the basis for revocation or suspension of accreditation. The division shall determine the appropriate action based on the information submitted. The division shall notify the organization in writing of any action taken.
[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.8(225C) Appeal procedure. An appeal may be filed using the procedure identified in 441—Chapter 7. Notice of an appeal shall be sent to Appeals Section, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut, Des Moines, Iowa 50319-0114, within 30 calendar days of the written decision from the commission.

441—24.9(225C) Exceptions to policy. Requests for exceptions to the policies in this chapter shall follow the policies and procedures in the department's general rule on exceptions to policy at 441—1.8(17A,217).

These rules are intended to implement Iowa Code chapter 225C.

441—24.10 to **24.19** Reserved.

DIVISION II
CRISIS RESPONSE SERVICES

PREAMBLE

The department of human services in consultation with the mental health and disability services commission has established this set of standards to be met by all providers of crisis response services.
[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.20(225C) Definitions.

"Action plan" means a written plan developed for discharge in collaboration with the individual receiving crisis response services to identify the problem, prevention strategies, and management tools for future crises.

"Crisis assessment" means a face-to-face clinical interview to ascertain an individual's current and previous level of functioning, potential for dangerousness, physical health, and psychiatric and medical condition. The crisis assessment becomes part of the individual's action plan.

"Crisis incident" means an occurrence leading to physical injury or death, or an occurrence resulting from a prescription medication error, or an occurrence triggering a report of child or dependent adult abuse.

"Crisis response services" means short-term individualized crisis stabilization services which follow a crisis screening or assessment and which are designed to restore the individual to a prior functional level.

"Crisis response staff" means a person trained to provide crisis response services in accordance with rule 441—24.24(225C).

"Crisis screening" means a process to determine what crisis response service is appropriate to effectively resolve the presenting crisis.

"Crisis stabilization community-based services" or *"CSCBS"* means short-term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and provided where the individual lives, works or recreates.

"Crisis stabilization residential services" or *"CSRS"* means a short-term alternative living arrangement designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis and is provided in organization-arranged settings of no more than 16 beds.

"Department" means the department of human services.

"Dispatch" means the function within crisis line operations to coordinate access to crisis care.

"Face-to-face" means services provided in person or utilizing telehealth in conformance with the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

"Family support peer specialist" means the same as defined in rule 441—25.1(331).

"Informed consent" means the same as defined in rule 441—24.1(225C).

"Mental health crisis" means a behavioral, emotional, or psychiatric situation which results in a high level of stress or anxiety for the individual or persons providing care for the individual and which cannot be resolved without intervention.

"Mental health professional" means the same as defined in Iowa Code section 228.1.

"Mobile response" means a mental health service which provides on-site, face-to-face mental health crisis services for an individual experiencing a mental health crisis. Crisis response staff providing mobile response have the capacity to intervene wherever the crisis is occurring, including but not limited to the individual's place of residence, an emergency room, police station, outpatient mental health setting, school, recovery center or any other location where the individual lives, works, attends school, or socializes.

"Peer support services" means a service provided by a peer support specialist, including but not limited to education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community.

"Peer support specialist" means the same as defined in rule 441—25.1(331).

"Physical health" means any chronic or acute health factors that need to be addressed during crisis delivery services.

"Qualified prescriber" means a practitioner or other staff following the instruction of a practitioner as defined in Iowa Code section 155A.3 and a physician assistant or advanced registered nurse practitioner operating under the prescribing authority granted in Iowa Code section 147.107.

"Restraint" means the application of physical force or the use of a chemical agent or mechanical device for the purpose of restraining the free movement of an individual's body to protect the individual, or others, from immediate harm.

"Rights restriction" means limitations not imposed on the general public in the areas of communications, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, and place of residence.

"Self-administered medication" means the process where a trained staff member observes an individual inject, inhale, ingest or, by any other means, take medication following the instructions of a qualified prescriber.

"Stabilization plan" means a written short-term strategy used to stabilize a crisis and developed by a mental health professional, in collaboration with the crisis response staff and with the involvement and consent of the individual or the individual's representative.

"Staff-administered medication" means the direct application of a prescription drug, whether by injection, inhalation, ingestion, or any other means, to the body of an individual by a qualified prescriber or authorized staff following instructions of a qualified prescriber.

"Telehealth" is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

"Treatment summary" means a written summarization of the treatment and action plan at the point of an individual's discharge or transition to another service.

"Twenty-four-hour crisis line" means a crisis line providing information and referral, counseling, crisis service coordination, and linkages to crisis screening and mental health services 24 hours a day.

"Twenty-four-hour crisis response" means services are available 24 hours a day, 365 days a year, providing access to crisis screening and assessment and linkage to mental health services.

"Twenty-three-hour observation and holding" means a level of care provided for up to 23 hours in a secure and protected, medically staffed, psychiatrically supervised treatment environment.

"Warm line" means a telephone line staffed by individuals with lived experience who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.21(225C) Standards for crisis response services. An organization may be accredited to provide any one or all of the identified crisis response services. An organization seeking crisis response service accreditation shall comply with the general standards within this division and additional standards for each specific service.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.22(225C) Standards for policies and procedures. Policies and procedures manuals contain policy guidelines and administrative procedures for all activities and services and address the standards in rule 441—24.2(225C).
[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.23(225C) Standards for organizational activities.

24.23(1) The organization shall meet the standards in subrules 24.3(1) through 24.3(5).

24.23(2) The organization shall describe the staffing structure that details how staff are utilized to provide the specific crisis stabilization services in rules 441—24.32(225C) through 441—24.39(225C).
[**ARC 1660C**, IAB 10/15/14, effective 12/1/14; **ARC 3057C**, IAB 5/10/17, effective 7/1/17]

441—24.24(225C) Standards for crisis response staff. All crisis response staff shall meet the qualifications described in this rule. Additional staff requirements are described in each service.

24.24(1) *Performance benchmark.* Qualified crisis response staff provide crisis response services.

24.24(2) *Performance indicators.*

a. One or more of the following qualifications are met:

(1) A mental health professional as defined in Iowa Code section 228.1.

(2) A bachelor's degree with 30 semester hours or equivalent in a human services field (including, but not limited to, psychology, social work, nursing, education) and a minimum of one year of experience in behavioral or mental health services.

(3) A law enforcement officer with a minimum of two years of experience in the law enforcement officer's field.

(4) An emergency medical technician (EMT) with a minimum of two years of experience in the EMT's field.

(5) A peer support specialist with a minimum of one year of experience in behavioral or mental health services.

(6) A family support peer specialist with a minimum of one year of experience in behavioral or mental health services.

(7) A registered nurse with a minimum of one year of experience in behavioral or mental health services.

(8) A bachelor's degree in a non-human services-related field, associate's degree, or high school diploma (or equivalency) with a minimum of two years of experience in behavioral or mental health services, and 30 hours of crisis and mental health in-service training (in addition to the required 30 hours of department-approved training).

b. Documentation in staff records to verify satisfactory completion of department-approved training including:

(1) A minimum of 30 hours of department-approved crisis intervention and training.

(2) A posttraining assessment of competency is completed.
[**ARC 1660C**, IAB 10/15/14, effective 12/1/14; **ARC 3057C**, IAB 5/10/17, effective 7/1/17]

441—24.25(225C) Standards for services.

24.25(1) *Standard for eligibility.* An eligible recipient is an individual experiencing a mental health crisis or emergency where a mental health crisis screening is needed to determine the appropriate level of care.

24.25(2) *Confidentiality and legal status.* Standards in subrule 24.4(6) are met.

24.25(3) *Service systems.* Standards in subparagraphs 24.4(7)*"b"*(1) to (3) are met.

24.25(4) *Respect for individual rights.* Standards in subrule 24.4(8) are met.
[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.26(225C) Accreditation. The administrator for the division of mental health and disability services shall determine whether to grant, deny or revoke the accreditation of the centers and services as determined in Iowa Code section 225C.6(1)*"c."*

24.26(1) The organization shall meet the standards of subrule 24.5(1), with the addition of crisis response service organizations.

24.26(2) The organization shall meet the standards in subrules 24.5(2) and 24.5(3).

24.26(3) Performance outcome determinations are as follows:

a. Quality assurance staff shall determine a performance compliance level based on the number of indicators found to be in compliance.

(1) For service indicators, if 25 percent or more of the files reviewed do not comply with the requirements for a performance indicator, that indicator is considered out of compliance and corrective action is required.

(2) Corrective action is required when any indicator under policies and procedures or activities is not met.

b. In the overall rating, the performance rating for policies and procedures shall count as 15 percent of the total, activities as 15 percent of the total, and services as 70 percent of the total.

(1) Each of the three indicators for policies and procedures has a value of 5.0 out of a possible score of 15.

(2) Each of the 34 indicators for activities has a value of .44 out of a possible score of 15.

(3) Each service has a separate weighting according to the total number of indicators applicable for that service, with a possible score of 70, as follows:

c. Quality assurance staff shall determine a separate score for each service to be accredited. When an organization offers more than one service under this chapter, there shall be one accreditation award for all the services based upon the lowest score of the services surveyed.

Service	Number of Indicators	Value of Each Indicator
24-hour crisis response	19	3.9
Crisis evaluation	20	3.5
24-hour crisis line	23	3.0
Warm line	20	3.5
Mobile response	18	3.9
23-hour observation and holding	44	1.6
Crisis stabilization, community-based	39	1.8
Crisis stabilization, residential	50	1.4

24.26(4) The organization shall meet the standards in subrules 24.5(5) to 24.5(7).

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.27(225C) Deemed status. The department shall grant deemed status to organizations accredited by a recognized national, not-for-profit, accrediting body when the department determines the accreditation is for similar services. The organization shall fulfill the standards described in subrules 24.6(1) to 24.6(6). The national accrediting bodies currently recognized as meeting division criteria for possible deeming are:

1. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
2. The Commission on Accreditation of Rehabilitation Facilities (CARF).
3. The Council on Quality and Leadership in Supports for People with Disabilities (The Council).
4. The Council on Accreditation of Services for Families and Children (COA).
5. The American Association of Suicidology (AAS).
6. Contact USA.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.28(225C) Complaint process. The department shall receive and record complaints by individuals using services, employees, any interested people, and the public relating to or alleging violations of applicable requirements of the Iowa Code or administrative rules in accordance with the standards described in rule 441—24.7(225C).

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.29(225C) Appeal procedure. The department shall receive appeals according to the process in rule 441—24.8(225C).
[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.30(225C) Exceptions to policy. The department shall receive exceptions to policy meeting the standards in rule 441—24.9(225C).
[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.31(225C) Standards for individual crisis response services. Crisis response services provided to children and youth include coordination with parents, guardians, family members, natural supports, and service providers and with other systems such as education, juvenile justice and child welfare.

Crisis response services for individuals who have co-occurring or multi-occurring diagnoses focus on the integration and coordination of treatment services, and supports necessary to stabilize the individual, without regard to which condition is primary. Crisis response services are not to be denied due to the presence of a co-occurring substance abuse condition or developmental or neurodevelopmental disability.
[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.32(225C) Crisis evaluation. Crisis evaluation consists of two components: crisis screening and crisis assessment.

24.32(1) *Crisis screening.* The purpose of crisis screening is to determine the presenting problem and appropriate level of care.

a. Performance benchmark. Crisis screening includes a brief assessment of suicide lethality, substance use, alcohol use and safety needs. Crisis screening can be provided through contact with crisis response staff and through communication with the individual.

b. Performance indicators.

(1) Crisis response staff are trained in crisis screening.

(2) A uniform process for crisis screening and referrals is outlined in policies and procedures.

(3) Crisis screening records are kept in individual files.

24.32(2) *Crisis assessment.* The purpose of crisis assessment is to determine the precipitating factors of the crisis, the individual and family functioning needs, and the diagnosis if present and to initiate a stabilization plan and discharge plan. A licensed mental health professional conducts a crisis assessment within 24 hours of an individual's admission to a crisis response service.

a. Assessment requirements. The crisis assessment includes:

(1) Action plan.

(2) Active symptoms of psychosis.

(3) Alcohol use.

(4) Coping ability.

(5) History of trauma.

(6) Impulsivity or absence of protective factors.

(7) Intensity and duration of depression.

(8) Lethality assessment.

(9) Level of external support available to the individual.

(10) Medical history.

(11) Physical health.

(12) Prescription medication.

(13) Crisis details.

(14) Stress indicators and level of stress.

(15) Substance use.

b. Performance benchmark. Individuals receive comprehensive assessment by a mental health professional to determine the appropriate level of care.

c. Performance indicators.

(1) Written policies and procedures describe a uniform process for assessment, referrals and record documentation.

(2) Mental health professionals as defined in Iowa Code section 228.1(6) will complete assessments.

(3) Information collected is sufficient to determine the appropriate level of care.

(4) Assessment results are explained to the individual and family or guardian when appropriate.

(5) The individual's strengths, preferences and needs are included in an action plan. The family or guardian may receive a copy of an action plan with a signed release.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.33(225C) Twenty-four-hour crisis response. The purpose of 24-hour crisis response is to provide access to crisis screening and assessment to de-escalate and stabilize the crisis. When the assessment indicates, a stabilization plan is developed to support the individual's return to a prior level of functioning. Twenty-four-hour crisis response staff link the individual to appropriate services. Crisis response staff provide service to individuals of any age.

24.33(1) *Performance benchmark.* Individuals in crisis have the ability to access crisis response services, including, but not limited to, crisis screening, crisis assessment and stabilization in the least restrictive level of care appropriate.

24.33(2) *Performance indicators.*

a. Information on how to access 24-hour crisis response is publicized to facilitate availability of services to individuals using the service, family members and the public.

b. Individuals accessing the service receive crisis screening and crisis response services from appropriate crisis response staff.

c. Crisis screening is available and accessible face-to-face, using telephone or Web-based options, 24 hours a day, 365 days a year.

d. A mental health professional is available for crisis assessment and consultation 24 hours a day, 365 days a year. The mental health professional has access to a qualified prescriber for consultation.

e. The staffing pattern and schedule is documented.

f. The integration and coordination of care is documented in the individual's record.

g. The discharge, action and follow-up plans are documented in the individual's record, and copies of the plans are provided to the individual. The family or guardian may receive a copy with a signed release.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.34(225C) Twenty-four-hour crisis line. A 24-hour crisis line provides counseling, crisis service coordination, information and referral, linkage to services and crisis screening. Crisis line staff are qualified to provide crisis stabilization services pursuant to subrule 24.24(2).

24.34(1) *Performance benchmark.* Crisis screening, counseling, crisis service coordination and referrals are provided to individuals in crisis.

24.34(2) *Performance indicators.*

a. The crisis line service is available 24 hours a day, 365 days a year.

b. Policies are in place regarding how the crisis line is answered live, when to utilize the hold feature, the use of queue systems and triage of calls.

c. Policies and procedures govern the use of technology, including telephonic and Internet capability in the service delivery structure, quality assurance, data integrity and confidentiality.

d. Procedures are in place for ensuring the quality of the crisis line, including monitoring calls and corrective action plans.

e. The crisis line is an integrated component of the crisis response service system; the crisis line is answered in an organization setting by trained crisis response staff.

f. Policies define collaborative efforts and triage procedure between the mobile outreach teams, law enforcement and emergency services.

g. Policies are in place to ensure follow-up contacts are provided within 24 hours of a crisis call for all risk cases. The crisis line integrates follow-up into all crisis service contacts.

h. The crisis line utilizes standardized call center software with the capability to track:

(1) Date and time of answered call, topic of call, crisis screening provided, referral made, hold time, and demographics of call.

(2) Number of contacts, including terminated and lost calls.

i. Policies and procedures describe a uniform process of crisis screening and training for crisis line staff.

j. Training includes crisis screening tools, lethality assessment, crisis counseling, cultural competence, crisis service coordination, and information and referral.

k. Twenty-four-hour access to a mental health professional is required.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.35(225C) Warm line. A peer-operated warm line is a service individuals can access to talk with someone with lived experience with mental, behavioral health and trauma issues. The line provides a resource for individuals experiencing emotional distress.

24.35(1) *Performance benchmark.* A warm line provides nonjudgmental listening, nondirective assistance, information, referral, and triage when appropriate.

24.35(2) *Performance indicators.*

a. Policies are in place regarding how the warm line is answered live, placing callers on hold and when appropriate to use a queue system.

b. Policies and procedures are in place for standard collection of demographics, the presented reason for calling and outcome of call.

c. Policies and procedures are in place for crisis screening and when to triage a caller to a higher level of service.

d. Data collection includes call answer times, duration of calls, and number of calls dropped, lost or terminated.

e. Policies and procedures describe the staffing pattern and schedule.

f. Warm-line staff can receive calls remotely through telephones or computers or within an organization.

g. Staff qualifications and training for peer support specialists and family support peer specialists are required.

h. Twenty-four-hour access to a mental health professional is required.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.36(225C) Mobile response. Crisis response staff provide on-site, in-person intervention for individuals experiencing a mental health crisis. The mobile response staff provide crisis response services in the individual's home or at locations in the community. Staff work in pairs to ensure staff safety and the safety of the individual served. A single staff member may respond if another person who meets one of the criteria listed in paragraph 24.24(2)*"a"* will be available on site. Twenty-four-hour access to a mental health professional is required.

24.36(1) *Performance benchmark.* Mobile response services are delivered to individuals in crisis in a timely manner.

24.36(2) *Performance indicators.*

a. Mobile response staff are dispatched immediately after crisis screening has determined the appropriate level of care. If the mobile response staff already are responding to another call, staff explain to the caller that there may be a delay in receiving a mobile response and offer an alternative response.

b. Mobile response staff have face-to-face contact with the individual in crisis within 60 minutes from dispatch. If the mobile response staff are responding to another request, there may be a delay in receiving mobile response and an alternative response should be provided.

c. Data is collected to track and trend response time from initial dispatch, the time to respond to dispatch when a team is already in response; diversion from or admission to hospitals, correctional facilities and other crisis response services. The data for each fiscal year is reported to the department within 60 days of the close of the fiscal year.

d. When an action plan is developed, a copy is sent within 24 hours, with the individual's signed consent, to service providers, the individual and others as appropriate.

e. The following information is documented in the individual's service record:

(1) Triage and referral information.

(2) Reduction in the level of risk present in the crisis situation.

(3) Coordination with other mental health resources.

(4) Names and affiliation of all individuals participating in the mobile response.

f. A follow-up appointment with the individual's preferred provider will be made, and mobile response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.37(225C) Twenty-three-hour crisis observation and holding. Twenty-three-hour crisis observation and holding services may be a stand-alone service or embedded within a crisis stabilization residential service. Twenty-three-hour crisis observation and holding services are designed for individuals who need short-term crisis intervention in a safe environment less restrictive than hospitalization. This level of service is appropriate for individuals who require protection or when an individual's ability to cope in the community is severely compromised and it is expected the crisis can be resolved in 23 hours. Twenty-three-hour crisis observation and holding services include, but are not limited to, treatment, medication administration, meeting with extended family or significant others, and referral to appropriate services. Twenty-three-hour crisis observation and holding chairs can be utilized.

24.37(1) *Admission criteria.* The services may be provided if any of the following admission criteria are met:

a. There are indications the symptoms can be stabilized and an alternative treatment can be initiated within a 23-hour period.

b. The presenting crisis cannot be safely evaluated or managed in a less restrictive setting, or no such setting is available.

c. The individual does not meet inpatient criteria, and it is determined a period of observation assists in the stabilization and prevention of symptom exacerbation.

d. Further evaluation is necessary to determine the individual's service needs.

e. There is an indication of actual or potential danger to self or others as evidenced by a current threat or ideation.

f. There is a loss of impulse control leading to life-threatening behavior and other psychiatric symptoms requiring stabilization in a structured, monitored setting.

g. The individual is experiencing a crisis demonstrated by an abrupt or substantial change in normal life functioning brought on by a specific cause, sudden event or severe stressor.

24.37(2) *Staffing requirements.*

a. A designated medical director or administrator is responsible for the management and operation of the organization or facility.

b. Registered nurse practitioners and physician assistants have at least two years of mental health experience.

c. At least one mental health professional is available for consultation 24 hours a day, 365 days a year.

d. A mental health professional as defined in Iowa Code section 228.1(6) provides mental health services appropriate to the individual's needs.

e. Crisis response staff are on duty 24 hours a day.

f. A registered nurse is available on site 24 hours a day.

24.37(3) *Twenty-three-hour observation and holding safety.*

a. Performance benchmark. An incident report is created when staff are notified an incident has occurred.

b. Performance indicators.

(1) The incident report documents:

1. The name of the individual or individuals who were involved in the incident.
2. Date and time of occurrence of the incident.
3. A description of the incident.
4. Names and signatures of all staff present at the time of the incident.
5. The action taken by the staff.
6. The resolution or follow-up to the incident.

(2) A copy of the incident report is kept in a centralized file and a copy is given to the individual, the mental health and disability services region, and the individual's parent or guardian when appropriate.

24.37(4) *Service requirements.*

a. Performance benchmark. A treatment summary is provided to the individual and the individual's treatment team when applicable.

b. Performance indicators. The minimum treatment summary requirements include:

(1) Action plan.

(2) Crisis assessment, including challenges and strengths.

(3) Course and progress of the individual with regard to each identified challenge.

(4) Evaluation of the individual's mental status to inform ongoing placement and support decisions.

(5) Recommendations and arrangements for further service needs.

(6) Signature of the mental health professional.

(7) Treatment interventions.

c. Performance benchmark. The individual using this service is provided a safe, secure observation and holding service in a location meeting the needs of the individual and in the least restrictive setting.

d. Performance indicators.

(1) Individuals give informed consent.

(2) Treatment providers, family members and other natural supports as appropriate are contacted within 23 hours of the individual's admission.

(3) Written policies and procedures cover medication administration, storage and documentation.

(4) Individual records include, but are not limited to, a treatment summary and verification of individual choice.

(5) The 23-hour crisis observation and holding facility is a welcoming and comfortable environment conducive to recovery.

(6) The 23-hour crisis observation and holding is primarily used as a diversion from hospital level of care.

(7) Communication attempts and contact with the individual's team will be documented.

(8) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

(9) There are written policies and procedures of how to document and track discharge locations.

(10) The actual number of individuals served within the 23-hour period is documented. Individual treatment records contain reasons why individuals stay beyond the 23-hour period.

(11) Readmission data and length of time between admissions are tracked for data trend reports.

e. Performance benchmark. Policies and procedures address the additional safety standards for 23-hour crisis and observation services.

f. Performance indicators.

(1) Service compliance is documented regarding state fire marshal rules and fire ordinances and applicable local health, fire, occupancy code, and safety regulations.

(2) Based on standards used for public facilities, all food and drink is clean, wholesome, free from spoilage, and stored and served in a manner safe for human consumption.

(3) Doors must not be locked from the inside. The use of door locks is as approved by the fire marshal and professional staff.

(4) Twenty-three-hour observation and holding services have an emergency preparedness plan to describe the process for an individual to continue receiving services during a disaster including, but not limited to, cases of severe weather or fire.

g. Performance benchmark. Policies and procedures address the cleanliness of the 23-hour observation and holding service.

h. Performance indicators.

(1) Services provide a safe, clean, well-ventilated, properly heated environment in good repair and free from vermin.

(2) An individual's resting or sleeping area includes:

1. A sturdily constructed bed or comfortable chair.
2. A sanitized mattress protected with a clean mattress pad, or sanitized chair.
3. Curtains or blinds are on bedroom windows.
4. Available clean linen.
5. Doors or partitions for privacy.
6. Right to privacy is respected.

(3) Bathrooms include items necessary for personal hygiene and personal privacy.

1. A safe supply of hot and cold running water which is potable.
2. Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap.
3. Natural or mechanical ventilation capable of removing odors.
4. Tubs or showers have slip-proof surfaces.
5. Partitions with doors which provide privacy if a bathroom has multiple toilet stools.
6. Toilets, wash basins, and other plumbing or sanitary facilities are maintained in good operating condition.
7. Privacy in bathrooms for male and female individuals.

i. Performance benchmark. Personal rights are acknowledged.

j. Performance indicator. The following are allowed:

(1) Areas in which an individual may be alone when appropriate.
(2) Areas for private conversations with others.
(3) Secure space for personal belongings.
(4) Personal clothing is allowed in accordance with organization policy.

k. Performance benchmark. Policies and procedures address health and safety standards.

l. Performance indicators.

(1) An emergency preparedness plan is designed to provide effective utilization of available resources during a disaster event including, but not limited to, cases of severe weather or fire.
(2) Services comply with rule 441—24.39(225C).
(3) There are written policies on safety.
(4) Seclusion is not used.
(5) Mechanical or chemical restraints are not used at any time.
(6) The smokefree air Act, Iowa Code chapter 142D, is followed.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.38(225C) Crisis stabilization community-based services (CSCBS). The goal of CSCBS is to stabilize the individual within the community. CSCBS is designed as a voluntary service for individuals in need of a safe, secure location that is less intensive and restrictive than an inpatient hospital. Individuals receive CSCBS services including, but not limited to, psychiatric services, medication, counseling, referrals, peer support and linkage to ongoing services. The duration for CSCBS is expected to be less than five days.

24.38(1) *Eligibility.* To be eligible, an individual must:

a. Be determined appropriate for the service by mental health assessment; and
b. Be determined not to need inpatient acute hospital psychiatric services.

24.38(2) *Staffing requirements.*

a. A designated director or administrator is responsible for the management and operation of the CSCBS.

b. At least one licensed nurse practitioner, physician assistant, or psychiatrist is available for consultation 24 hours a day, 365 days a year.

c. Mental health professionals with expertise appropriate to the individual's needs provide services.

d. Contact between the individual and a mental health professional occurs at least one time a day.

e. Additional services are provided by crisis response staff at a minimum of one hour per day, including, but not limited to, skill building, peer support or family support peer services. The goal of CSCBS is to stabilize the individual within the community. CSCBS is designed for voluntary services for individuals in need of a safe, secure location that is less intensive and restrictive than an inpatient hospital.

f. Crisis response staff must be awake and attentive 24 hours a day.

24.38(3) *Performance benchmark.* The individual using CSCBS is provided safe, secure and structured crisis stabilization services in the least restrictive location meeting the needs of the individual. The CSCBS can be for youth aged 18 and under or adults aged 18 and older.

24.38(4) *Performance indicators.*

a. The individual can provide consent for treatment providers, family members and other natural supports to be contacted within 24 hours of admission.

b. Daily crisis stabilization services include, at minimum, daily contact with a mental health professional and one hour of additional crisis stabilization services from crisis response staff.

c. The numbers of days an individual receives crisis stabilization services are documented. The documentation records specific reasons for the delivery of services beyond five days.

d. Individual records are maintained to document the following:

(1) Daily contact with a mental health professional.

(2) Additional services provided including, but not limited to, skill building, peer support or family support peer services.

(3) Medication record.

e. Individual choice is verified including, but not limited to, treatment participation and discharge plan options.

f. Readmission data is tracked, including an analysis of data trends looking at effectiveness, and appropriate corrective action taken. The information is documented in the performance improvement system files.

24.38(5) *Crisis stabilization incident reporting.*

a. Performance benchmark. An incident report is filed when staff are notified an incident has occurred.

b. Performance indicators.

(1) The incident report documents:

1. The name of the individual involved in the incident.
2. Date and time the incident occurred.
3. A description of the incident.
4. Names and signatures of all staff present at the time of the incident.
5. The action the staff took to handle the situation.
6. The resolution or follow-up to the incident.

(2) A copy of the incident report is kept in a centralized file and a copy given to the individual, the mental health and disability services region, and the parent or guardian when appropriate.

24.38(6) *Service requirements.*

a. Stabilization plan. The individual in crisis is involved collaboratively in all aspects of crisis stabilization services including, but not limited to, admission, treatment planning, intervention, and discharge. The involvement of family members and others is encouraged.

Within 24 hours of an individual's admission to crisis stabilization services, a written short-term stabilization plan is developed, with the involvement and consent of the individual, and is reviewed frequently to assess the need for the individual's continued placement in CSCBS. At a minimum, this plan includes:

(1) Criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems.

(2) Description of any physical disability and any accommodations necessary to provide the same or equal services and benefits as those afforded nondisabled individuals.

(3) Evidence of input by the individual, including the individual's signature.

(4) Goal statement. Goals are consistent with the individual's needs and projected duration of service delivery and include objectives which build on strengths and are stated in terms allowing measurement of progress.

(5) Rights restrictions.

(6) Names of all other persons participating in the development of the plan.

(7) Specification of treatment responsibilities and methods.

b. Performance benchmark. A stabilization plan is completed within 24 hours of the individual's admittance.

c. Performance indicators.

(1) Individual records include a written short-term stabilization plan developed with the involvement and consent of the individual within 24 hours of admittance and reviewed frequently to assess the need for continued placement in CSCBS.

(2) Individual records indicate a crisis stabilization plan is completed within the 24-hour time frame.

(3) Reasons for crisis stabilization plans not meeting the criteria are documented.

(4) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

24.38(7) *Treatment summary.* Prior to the individual's discharge from CSCBS, a treatment summary is completed. A copy of the summary is provided to the individual and shared with the individual's treatment team of providers, if applicable.

a. Contents. At a minimum, the treatment summary includes:

(1) Course and progress of the individual with regard to each identified problem.

(2) Documented note of a mental health professional contact one time daily.

(3) Evolution of the mental status to inform ongoing placement and support decisions.

(4) Final assessment, including general observations and significant findings of the individual's condition initially while services were being provided and at discharge.

(5) Recommendations and arrangements for further service needs.

(6) Signature of the mental health professional.

(7) Stabilization plan.

(8) Reasons for termination of service.

(9) Treatment interventions.

b. Performance benchmark. A treatment summary is completed during the length of stay in CSCBS.

c. Performance indicators.

(1) Records include a written treatment summary developed with the involvement of the individual. A copy of the summary is provided upon discharge.

(2) Incidents in which a treatment plan was not completed within the length of stay and any corrective action necessary to alleviate this issue are documented.

24.38(8) *Health and safety.*

a. Performance benchmark. Emergency preparedness policies and procedures include health and safety measures.

b. Performance indicators.

(1) Emergency preparedness plans are designed to provide effective utilization of available resources for care to continue during a disaster event including, but not limited to, cases of severe weather or fire.

(2) Crisis services comply with rule 441—24.39(225C).

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.39(225C) Crisis stabilization residential services (CSRS). Crisis stabilization residential services are short-term services provided in facility-based settings of no more than 16 beds. The goal of CSRS is to stabilize and reintegrate the individual back into the community. Crisis stabilization residential services are designed for voluntary individuals who are in need of a safe, secure environment less intensive and restrictive than an inpatient hospital. Crisis stabilization residential services have the capacity to serve more than two individuals at a time. Crisis stabilization residential services can be for youth aged 18 and younger or adults aged 18 and older. Youth and adults cannot be housed in the same facility setting. Facilities licensed by the department of inspections and appeals for other services would have to comply with the provisions of Iowa Administrative Code rule 481—57.50(135C) for operating another business or activity in the facility.

24.39(1) *Eligibility.* To be eligible, an individual must:

a. Be an adult aged 18 or older or a youth aged 18 or under.

b. Be determined appropriate for the service by a mental health assessment; and

c. Be determined to not need inpatient acute hospital psychiatric services.

24.39(2) *Staffing requirements.*

a. A designated director or administrator is responsible for the management and operation of the CSRS of no more than 16 beds.

b. At least one licensed mental health professional is available for consultation 24 hours a day, 365 days a year.

c. Crisis stabilization residential services are provided by a mental health professional with expertise appropriate to the individual's needs.

d. Each individual has contact with a mental health professional at least one time a day.

e. Each individual has a minimum of one hour per day of additional services provided by crisis response staff including, but not limited to, skill building, peer support or family support peer services; or other therapeutic programming.

f. Awake and attentive staffing 24 hours a day, 365 days a year is provided.

24.39(3) *Performance benchmark.* The individual is provided safe, secure and structured crisis stabilization services in the least restrictive location meeting the individual's needs.

24.39(4) *Performance indicators.*

a. Individual's consent is documented, and treatment providers, family members and other natural supports are contacted within 24 hours of admission.

b. A comprehensive mental health assessment is completed within 24 hours of admission.

c. Daily crisis stabilization includes, at minimum, daily contact with a mental health professional and one hour of additional crisis stabilization service.

d. The length of stay is expected to be less than five days.

e. The number of days an individual receives crisis stabilization services is documented. The documentation records specific reasons for lengths of stay beyond five days.

f. Records include:

(1) Stabilization plan.

(2) Medication record.

(3) Treatment summary.

(4) Daily contact with a mental health professional.

g. Additional services provided include, but are not limited to, skill building, peer support or family support peer services.

h. Individual choice is verified including, but not limited to, treatment participation and discharge plan options.

i. Data of readmission is tracked including an analysis of data trends, looking at effectiveness, and appropriate corrective action. The information is documented in the performance improvement system.

j. Documentation tracks that the youth's education needs are met with educational services received in the CSRS, and an action plan is in place to return the youth to school upon discharge.

24.39(5) *Crisis stabilization incident reporting.*

a. Performance benchmark. An incident report is completed when staff are notified an incident has occurred.

b. Performance indicators.

(1) The incident report documents:

1. The name of the individual who was involved in the incident.
2. Date and time of occurrence of the incident.
3. A description of the incident.
4. Names and signatures of all staff present at the time of the incident.
5. The action staff took to handle the situation.
6. The resolution or follow-up to the incident.

(2) A copy of the incident report is maintained in a centralized file and a copy given to the individual, the mental health and disability services region, and the parent or guardian when appropriate.

24.39(6) *Service requirements.*

a. Stabilization plan. The individual is involved collaboratively in all aspects of crisis stabilization services including, but not limited to, admission, treatment planning, intervention, and discharge. The involvement of family members and others is encouraged.

Within 24 hours of admission to CSRS, a written short-term stabilization plan is developed, with the involvement and consent of the individual, and reviewed frequently to assess the need for continued placement in CSRS. At a minimum, this plan includes:

(1) Criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems.

(2) Description of any physical disability and accommodations necessary to provide the same or equal services and benefits as those afforded nondisabled individuals.

(3) Evidence of input by the individual, including the individual's signature.

(4) Goal statement.

(5) Goals consistent with needs and projected length of stay.

(6) Objectives that are built on strengths and allow measurement of progress.

(7) Rights restrictions.

(8) Signatures of all participating in the development of the plan.

(9) Specification of treatment responsibilities and methods.

b. Performance benchmark. A stabilization plan is completed within 24 hours of admittance.

c. Performance indicators.

(1) Records include a written short-term stabilization plan developed with the involvement and consent of the individual within 24 hours of admission and is reviewed frequently to assess the need for continued placement in CSRS.

(2) Records indicating a stabilization plan has been completed within the 24-hour time frame are maintained.

(3) Reasons the stabilization plan does not meet the criteria is documented.

(4) A follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

24.39(7) *Treatment summary.* Prior to discharge, a treatment summary is provided and a copy shared with the individual and treatment team as appropriate.

a. Contents. At a minimum, this treatment summary includes:

(1) Course and progress regarding each identified problem.

(2) Documentation of daily contact with a mental health professional.

(3) Impact on placement and support decisions.

(4) Assessment.

(5) Action plan.

(6) Stabilization plan.

(7) Treatment interventions.

(8) Reasons for termination of service.

(9) Signature of the mental health professional.

b. Performance benchmark. A treatment summary is completed during the individual's length of stay in CSRS.

c. Performance indicators.

(1) Records include a written treatment summary developed with the involvement and consent of the individual.

(2) An individual receives a copy of the treatment summary upon discharge.

(3) Corrective action steps are documented when treatment plans are not completed within the length of stay.

24.39(8) *Health and safety.*

a. Performance benchmarks.

(1) Emergency preparedness policies and procedures include health and safety measures.

(2) Crisis stabilization services meet all applicable local, state and federal regulations.

(3) Medication administration and documentation standards in rule 441—24.40(225C) are documented.

b. Performance indicators.

(1) Health and fire safety inspections.

1. Documentation includes Iowa fire marshal rules and fire ordinances, local health, fire, occupancy code, and safety regulations.

2. Standards for public facilities guide food and beverage safety, nutrition standards, and safe storage of all consumable products.

3. Crisis stabilization residential services comply with rule 441—24.40(225C).

(2) Emergency preparedness. Emergency preparedness policies are designed to provide effective utilization of available resources for continuation during a disaster event, including, but not limited to, cases of severe weather or fire.

(3) The facility is safe, clean, well-ventilated, and a properly heated environment in good repair and free from vermin.

(4) Bedrooms include:

1. A sturdily constructed bed.

2. A sanitized mattress protected with a clean mattress pad.

3. A designated space in proximity to the sleeping area for personal possessions including clothing.

4. Curtains or window blinds on bedroom windows.

5. Available clean linens.

(5) Sleeping areas include:

1. Doors for privacy.

2. Partitioning and placement of furniture to provide privacy.

3. Rooms accommodate no more than two per room. Single room dimensions are at least 80 square feet not including closets. Dual occupancy rooms are at least 120 square feet not including closets.

4. Personal belongings and personal touches in the rooms are defined within CSRS policy.

5. Respect by staff for an individual's right to privacy.

(6) Personal hygiene and privacy tools are provided:

1. A safe supply of hot and cold running water which is potable.

2. Clean towels, electric hand dryers or paper towel dispensers, and an available supply of toilet paper and soap.

3. Natural or mechanical ventilation capable of removing odors.

4. Tubs or showers with slip-proof surfaces.

5. Partitions with doors which provide privacy if a bathroom has multiple toilet stools.

6. Toilets, wash basins, and other plumbing or sanitary facilities are in good operating condition.

7. Privacy in bathrooms for male and female individuals.

(7) Federal laws regarding smoking on property are recognized and followed.

(8) The following is provided:

1. Areas in which an individual may be alone when appropriate.

2. Areas for private conversations with others.

3. A secure space for personal belongings.

c. Housekeeping. Maintenance of living quarters and day-to-day housekeeping activities are clearly defined in writing and a part of the orientation. Staff assistance and equipment are provided as needed.

d. Clothing.

(1) Personal clothing is allowed in accordance with CSRS policy.

(2) Clothing may be washed with provided laundry mechanisms.

e. Religion/culture. Rights to religion and culture include:

(1) The opportunity to participate in religious activities and services in accordance with the individual's faith or of a minor individual's parent(s) or guardian.

(2) Arrange for transportation to religious activities when appropriate per CSRS policy.

f. Smoking. The smokefree air Act, Iowa Code chapter 142D, is included in the CSRS policy.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14]

441—24.40(225C) Medication—administration, storage and documentation. This rule sets forth medication requirements for 23-hour crisis observation and holding, crisis stabilization community-based services, and crisis stabilization residential services.

24.40(1) *Performance benchmark.* Policies and procedures ensure prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations. Medication is administered by a qualified prescriber or an individual following the instructions of a qualified prescriber. Medication storage is maintained in accordance with the security requirements of federal, state and local laws. Case records include written policies and procedures regarding use of medication.

24.40(2) *Performance indicators.*

a. Administration of medication.

(1) Medication administration dose schedules and standardization of abbreviations are documented.

(2) Throughout the CSRS specific methods for control and accountability of medication products are established.

(3) Prescription and over-the-counter drugs are administered or self-administered safely and properly in accordance with federal, state and local laws and regulations.

(4) Medications are prescribed by a qualified prescriber under Iowa law.

(5) Prescription drugs are not administered or self-administered without a written order signed by a qualified prescriber.

b. Staff-administered medication.

(1) Only qualified and authorized staff administers medication, and a current, accurate list of staff is maintained.

(2) Qualified prescribers instruct how medications are administered and documented. The type and amount of medication, time and date of medication administered, and the name of staff administering the medication are transcribed in the medication record.

c. Self-administered medication.

(1) Policies and procedures document which staff have completed department-approved training on self-administration of prescription medication.

(2) Self-administration of prescription and over-the-counter medications are permitted only when the medication label is clear and complete.

d. Medication storage. Medication storage policies under the care and control of the administration include:

(1) All medication is maintained in locked storage, and controlled substances are maintained in a locked box within locked storage.

(2) Medications requiring refrigeration are kept in a refrigerator separated from food and other edible items.

(3) Disinfectants and medication for external use are stored separately from internal and injectable medications.

(4) Each medication is stored in original containers and labeled with the name.

(5) All potent poisonous or caustic medications are clearly labeled; stored separately from other medication, in a specific well-illuminated cabinet, closet, or storeroom; and made accessible only to authorized staff.

(6) Medication provided is dispensed from a licensed pharmacy in the state of Iowa in accordance with the Iowa Code. It can also be provided by a qualified prescriber from a licensed pharmacy in another state according to the laws of the state.

(7) Prescription medications prescribed for one individual are not administered or allowed in the possession of another.

e. Medication labeling. All prescribed medications are clearly labeled with the full name; prescriber's name; prescription number; name and strength of the medication; dosage; directions for use; date of issue; and name, address and telephone number of the pharmacy or prescriber issuing the medication. Medications are packaged and labeled according to state and federal guidelines.

f. Monthly inspection. The staff member in charge of medication provides monthly inspection of all storage units.

g. Damaged labels. Medication containers having soiled, damaged, illegible, or makeshift labels are returned to the issuing pharmacist, pharmacy, or qualified prescriber for relabeling or disposal.

h. Unused medications. Unused prescription drugs are destroyed by staff with a witness present, when an individual leaves the crisis service without medication. A notation is documented in the record. When an individual is discharged or leaves the crisis service, medications currently being administered are sent in their original containers with the individual or with a designated person, with the approval of the qualified prescriber.

i. Medication brought by individual. If the prescribed and over-the-counter medication the individual brings to the CSRS is not used, the medication is packaged, sealed and stored. The sealed packages of medications are returned to the individual or family at the time of discharge.

j. Medication documentation.

(1) Written policies and procedures are in place for the review, approval, and implementation of ethical, safe, human and efficient behavioral intervention procedures.

(2) Written policies and procedures are in place to inform the individual and the individual's legal guardian, when appropriate, about prohibitions on the use of medication as a restraint.

(3) Documentation is required in case records on adverse drug reactions when medications are administered and self-administered.

(4) All medication orders are documented in the case records and document the name of the medication, dose, route of administration, frequency of administration, name of the qualified prescriber prescribing the medication, and name of the staff administering or dispensing the medication.

(5) Medication records are documented by authorized staff administering the medication.

k. Medication rights and responsibilities.

(1) Medication is not used as a restraint. The use of psychopharmacological medication in excess of the standard plan of care is prohibited. Using medication as a restraint includes:

1. Drugs or medications used to control behavior or restrict freedom of movement.
2. Drugs or medications used in excessive amounts or in excessive frequency.
3. Neuroleptics, anxiolytics, antihistamines, and atypical neuroleptics, or other medication used for calming, rather than for the medication's indicated treatment.

(2) Drugs or medications used for standard treatment of the individual's medical or psychiatric condition are not considered to be used as a restraint.

[**ARC 1660C**, IAB 10/15/14, effective 12/1/14; **ARC 6321C**, IAB 5/18/22, effective 7/1/22]

These rules are intended to implement Iowa Code sections 331.397 and 225C.19A and chapter 230A.

441—24.41 to **24.49** Reserved.

DIVISION III
COMMUNITY MENTAL HEALTH CENTERS

PREAMBLE

The department of human services in consultation with the mental health and disability services commission has established this set of standards to be met by all designated community mental health centers (CMHCs). CMHCs are to provide an organized set of services to adequately meet the mental health needs of individuals in their catchment area. It is the department's responsibility to designate at least one community mental health center for addressing the mental health needs of the county or counties comprising a catchment area in accordance with Iowa Code chapter 230A.

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.50(230A) Definitions.

"Catchment area" means the same as defined in Iowa Code section 230A.102(2).

"Community mental health center self-assessment" means the form completed and submitted to the department by a new organization as part of the initial application to be designated as a CMHC. Designated

CMHCs complete the form annually and submit it to the department as part of the accreditation and CMHC monitoring process.

"Community support services" or *"CSS"* means services that support individuals with a mental illness and functional impairment to live and work in the community of their choice through assisting with:

1. Monitoring of mental health symptoms and functioning/reality orientation;
2. Transportation;
3. Supportive relationship;
4. Communication with other providers;
5. Ensuring individual attends appointments/obtains medications;
6. Crisis intervention/developing crisis plan; and
7. Coordination and development of natural support systems for mental health support.

"Functional impairment," for the purpose of this division, means difficulties that substantially interfere with or limit functioning in one or more major life activities, such as basic daily living (including but not limited to eating, bathing, dressing); instrumental living skills (including but not limited to maintaining a household, managing money, community involvement, taking prescribed medication); and functioning in social, family and vocational/educational contexts.

"Psychosocial rehabilitation services" means services that promote recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychosocial rehabilitation services are collaborative, person-directed and individualized. The service focuses on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

"Target population" means the same as defined in Iowa Code section 230A.105.

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.51(230A) Community mental health center designation.

24.51(1) *Application.* An organization seeking designation as a community mental health center or a designated community mental health center seeking to expand its designated catchment area shall submit the following to the department:

a. Form 470-3005, Accreditation Application, if requesting accreditation for a CMHC core service(s) other than outpatient psychotherapy and evaluation.

b. Form 470-5691, Community Mental Health Center Designation, signed by the organization's chief executive officer and the chairperson of the governing body.

c. Form 470-5692, Community Mental Health Center Self-Assessment.

24.51(2) *Exceptional circumstances.* Designation for more than one CMHC in a county shall require a determination of exceptional circumstances by the department.

a. Applicants requesting designation for a county that is part of another CMHC's catchment area shall submit information supporting their designation request including, but not limited to, the following:

(1) Evidence that the target population does not have access to the required core services with minimal or no service denials.

(2) Ability to staff core services within the capacity of the catchment area's workforce.

(3) Mental health and disability services (MHDS) region(s) letter of support that includes the catchment area's ability to financially support more than one CMHC.

(4) Notification to the existing CMHC of intention to apply for designation.

(5) Evidence of collaboration and coordination with existing CMHC.

b. Paragraph 24.51(2)*"a"* and numbered paragraph "2" in rule 441—24.52(230A) do not apply to CMHCs designated as described in Iowa Code section 230A.104(2)*"c."*

24.51(3) *Designation.* The department shall review information submitted by the applicant in accordance with subrule 24.51(1), subrule 24.51(2), and paragraph 24.51(3)*"a"* as well as input from MHDS regions, neighboring CMHCs, and mental health service providers to determine if there will be a recommendation for designation. Recommendations for designation shall be submitted by the department to the MHDS commission for approval.

a. Applicants shall submit the following:

(1) MHDS region(s) letter of support.

(2) Evidence of active three-year accreditation for outpatient and evaluation services under this chapter.

(3) Formal agreement with appropriately accredited provider if the applicant is not directly providing the service for the following:

1. Day treatment, partial hospitalization, or psychosocial rehabilitation services, and
2. Emergency or 24-hour crisis response.

(4) Form 470-5692, Community Mental Health Center Self-Assessment, that demonstrates the applicant's ability to:

1. Provide core services in accordance with rule 441—24.54(230A).
2. Meet service access standards according to 441—subparagraph 25.4(2)*"a"*(1) and 441—paragraphs 25.4(3)*"a"* and *"c."*
3. Serve all ages of the target population with minimal to no service denials.
4. Make referrals for services provided outside the organization.

b. The department shall notify the applicant in writing of the result of the review. If the department recommends designation, the applicant shall attend the MHDS commission meeting at which the department presents the request to the commission.

c. CMHCs designated in accordance with Iowa Code chapter 230A prior to January 1, 2021, or designated as a CMHC by a county prior to October 1, 2010, will maintain their designation provided they meet the requirements set forth in rule 441—24.55(230A).

d. Non-CMHC agencies designated as described in Iowa Code section 230A.107(2) may apply to be designated as a CMHC. The organization shall submit all required application materials in this subrule at least six months prior to the expiration of the organization's current accreditation under this chapter.

24.51(4) *Withdrawal of designation.* Community mental health centers seeking to withdraw their designation for part or all of their catchment area shall submit to the department Form 470-5691, Community Mental Health Center Designation, signed by the organization's chief executive officer and the chairperson of the governing body. The form shall include:

a. Current catchment area and catchment area requesting withdrawal of designation.

b. Reason for withdrawal request.

c. Date withdrawal is to occur.

d. Continuity of care plan including but not limited to communication and coordination with:

(1) Individuals served.

(2) Community mental health centers and mental health service providers serving neighboring and current catchment area.

(3) MHDS region(s).

(4) General public.

24.51(5) *Agreement.* The board of directors of a designated CMHC shall enter into an agreement with the department in accordance with Iowa Code section 230A.103(3).

24.51(6) *Appeal procedure.* An appeal to a designation determination may be filed in accordance with rule 441—24.8(225C).

24.51(7) *Exception to policy.* Requests for exceptions to policy shall be submitted in accordance with rule 441—24.9(225C).

24.51(8) *Denial of designation or revocation.* The department may deny or revoke the provider's designation at any time for any of the following reasons:

a. The provider has failed to provide information requested pursuant to subrule 24.51(1).

b. The provider does not meet criteria pursuant to subrule 24.51(3).

c. The provider refuses to allow the department to conduct a site visit pursuant to subrule 24.5(3).

d. The provider has failed to implement the corrective actions submitted and approved by the department pursuant to subrule 24.55(2).

e. The provider's accreditation was discontinued or revoked pursuant to paragraph 24.5(5)*"h."*

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.52(230A) Standards for policies and procedures. Policies and procedures manuals shall include policy guidelines and administrative procedures for:

1. Core services and supports,
2. Serving the target population with minimal to no service denials,
3. Addressing the standards in rule 441—24.2(225), and
4. Ensuring an individual's ability to access services regardless of ability to pay. The CMHC shall assist individuals with applying for health insurance and MHDS regional assistance when necessary to ensure access to services.

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.53(230A) Standards for organizational activities. The organization shall meet all requirements in rule 441—24.3(225C) and the standards identified in this rule.

24.53(1) A CMHC organized as a nonprofit corporation shall be governed by a board of directors consistent with the requirements identified in Iowa Code section 230A.110(3)*"b."*

24.53(2) A CMHC organized as a for-profit corporation shall have a policy structure that incorporates the representation identified in Iowa Code section 230A.110(3)*"b."*

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.54(230A) Standards for core services and supports.

24.54(1) *Outpatient services.* Outpatient services include outpatient psychotherapy and counseling services and evaluation. These services are to be provided directly by the CMHC.

a. Outpatient psychotherapy and counseling services shall be provided in accordance with subrule 24.4(14) and shall include treatment modalities and evidence-based practices for children, adults, older adults, individuals with co-occurring conditions, and individuals discharged from inpatient settings. Clinical eligibility is determined at the time of initial assessment and annually thereafter in accordance with subrule 24.4(2).

b. Evaluation services shall be provided in accordance with subrule 24.4(16).

24.54(2) *Twenty-four-hour emergency services.* The organization shall provide or enter into a formal agreement with an accredited provider for at least one of the following:

a. Emergency services provided in accordance with subrule 24.4(15).

b. Twenty-four-hour crisis response provided in accordance with rule 441—24.33(225C).

24.54(3) *Day treatment, partial hospitalization, or psychosocial rehabilitation services.* The organization shall provide or enter into a formal agreement with an accredited provider for at least one of the following:

a. Day treatment provided in accordance with subrule 24.4(10), or

b. Partial hospitalization provided in accordance with subrule 24.4(13), or

c. Psychosocial rehabilitation services. This shall include at least one of the following:

(1) Assertive community treatment (ACT) provided in accordance with 441—subrule 25.6(2) and rule 441—77.38(249A).

(2) Intensive psychiatric rehabilitation services provided in accordance with subrule 24.4(11).

24.54(4) *Admission screening for voluntary patients to a state mental health institute.*

a. Screening and evaluation shall be made available to individuals requesting admission to a state mental health institute.

b. The organization shall have policies and procedures that define the process to assist an individual seeking voluntary admission to a state mental health institute and to refer the individual to other services if treatment at the mental health institute is not immediately available.

24.54(5) *Community support services (CSS).* The purpose of CSS is to support individuals as they live and work in the community and address mental health symptoms and functional impairments that negatively affect integration and stability in the community.

a. Performance benchmark.

(1) Qualified staff provide CSS.

(2) CSS is provided to individuals in the target population with a mental illness and functional impairment.

b. Performance indicators.

(1) The following staff qualifications shall be met:

1. Have knowledge and experience in working with the target population.

2. Have the ability to create relationships with the individuals served that balance support of the mental illness and the need to allow for maximum individual independence.

3. Have a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field, including but not limited to psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy.

4. Complete a minimum of 12 hours of training within the first year of employment and annually in mental health conditions, including but not limited to the following topics:

- Mental health diagnoses, symptomology, and treatment;
- Crisis management, intervention, and de-escalation;
- Psychiatric medications, common medications, and potential side effects;
- Other diagnoses or conditions present in the population served; and
- Individual person-centered service plan, crisis plan, and behavioral support plan implementation.

(2) The following service components are provided:

1. Monitoring of mental health symptoms and functioning/reality orientation.
2. Transportation.
3. Supportive relationship.
4. Communication with other providers.
5. Ensuring individuals attend appointments and obtain medications.
6. Crisis intervention and developing a crisis plan.
7. Coordination and development of natural support systems for mental health support.

24.54(6) *Consultation services.* Consultation services shall be provided in accordance with Iowa Code section 230A.106(2)*"f."*

24.54(7) *Education services.* Education services shall be provided in accordance with Iowa Code section 230A.106(2)*"g."*

24.54(8) *Coordination with unaffiliated agencies.* Coordination shall be provided in accordance with Iowa Code section 230A.106(3).

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

441—24.55(230A) Accreditation of community mental health centers.

24.55(1) The provider shall be accredited as a provider of outpatient psychotherapy and counseling pursuant to subrule 24.4(14) and evaluation pursuant to subrule 24.4(16) and meet the standards of rule 441—24.3(225C).

24.55(2) The provider shall meet the standards in rules 441—24.52(230A), 441—24.53(230A), and 441—24.54(230A). Corrective action is required when any indicator under community mental health designation standards is not met.

24.55(3) The provider shall annually submit Form 470-5692, Community Mental Health Center Self-Assessment, to the department.

[**ARC 6321C**, IAB 5/18/22, effective 7/1/22]

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[1] Effective date of definitions of "Administrator," "Division" and "Persons with mental retardation" delayed 70 days by the Administrative Rules Review Committee at its meeting held April 10, 1995.

CHAPTER 25
DISABILITY SERVICES MANAGEMENT
Rescinded **ARC 9274C**, IAB 5/14/25, effective 7/1/25

CHAPTER 26
COUNTY MAINTENANCE OF EFFORT CALCULATIONS AND REPORTING
Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 27
Reserved

CHAPTER 28
POLICIES FOR MENTAL HEALTH INSTITUTES AND RESOURCE CENTER

[Prior to 7/1/83, Social Services [770] Ch 28]
[Prior to 2/11/87, Human Services [498]]

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

441—28.1(218) Definitions. The definitions in this rule apply to 441—Chapters 28, 29, and 30.

"Admission" means the acceptance of an individual for receipt of services at a state mental health institute or the Woodward state resource center on either a voluntary or involuntary basis.

"Adult" means an individual who is 18 years of age or older.

"Facility" means a mental health institute or the Woodward state resource center referenced in Iowa Code section 218.1.

"Grievance" means a written or oral complaint by or on behalf of an individual involving:

1. A rights violation or unfairness to the individual, or
2. Any aspect of the individual's life with which the individual does not agree.

"Guardian" means the person other than a parent of a minor who has been appointed by the court to have custody of the person of the individual as provided under Iowa Code section 232.2(24) or 633.3(20).

"Individual" means any person seeking or receiving services from a state mental health institute or the Woodward state resource center.

"Informed consent" means an agreement by an individual or by the individual's parent, guardian, or legal representative to participate in an activity based upon an understanding of all of the following:

1. A full explanation of the procedures to be followed, including an identification of those that are experimental.
2. A description of the discomforts and risks.
3. A description of the benefits to be expected.
4. A disclosure of appropriate alternative procedures that would be advantageous for the individual.
5. Assurance that consent is given freely and voluntarily without fear of retribution or withdrawal of services.

"Legal representative" means a person, including an attorney, who is authorized by law to act on behalf of an individual.

"Minor" means an individual under the age of 18.

"Non-Medicaid payment-eligible" means that an individual is not eligible for Medicaid funding for the services provided by a mental health institute or the Woodward resource center.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"Superintendent" means the superintendent of either of the two mental health institutes or the Woodward state resource center.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—28.2(222,230) Payor of last resort. The department will review a non-Medicaid payment-eligible individual's financial and third-party coverage information to ensure the state is the payor of last resort. Third-party coverage does not include payment by an administrative services organization as defined in Iowa Code section 225A.1.

This rule is intended to implement Iowa Code sections 222.35 and 230.23.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—28.3(229) Grievances. Any individual who believes the individual's rights have been violated by a mental health institute or resource center or who has any complaint concerning the individual's treatment

at a mental health institute or resource center may file a grievance. A grievance will be filed using the individual grievance form. The individual's parent, family, guardian, or legal representative may file a grievance on behalf of the individual.

This rule is intended to implement Iowa Code section 229.23.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—28.4(217,218) Photographing and recording of individuals and use of cameras.

28.4(1) Use of still or video cameras or voice recorders by anyone other than an authorized employee, individual, parent, guardian, or legal representative to photograph or record an individual will be allowed only with the prior authorization of the superintendent or the superintendent's designee. Permission to photograph and record will be granted for one specific use, and the authorization will not extend to any other use.

28.4(2) Photographs, videos, and recordings of an adult individual will be taken for publication only with a signed informed consent from the individual or the individual's guardian or legal representative.

28.4(3) Photographs, videos, and recordings of a minor individual will be taken for publication only with a signed informed consent from the parent, guardian, or legal representative.

28.4(4) Every effort will be made to preserve the inherent dignity of the individual and to preclude exploitation or embarrassment of the individual or the family of the individual.

28.4(5) Photographs, videos, and recordings of individuals are not to be altered to prevent identification in any manner that would tend to perpetuate the stigma attached to the public image of individuals with mental illness or an intellectual disability.

This rule is intended to implement Iowa Code sections 217.30 and 218.4.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—28.5(217,218) Interviews and statements.

28.5(1) Releases to the news media will be the responsibility of the superintendent. Authority for dissemination and release of information may be designated to other employees at the discretion of the superintendent.

28.5(2) Interviews of individuals by the news media or other outside persons or groups will be permitted only with the consent of the individual or the individual's parent, guardian, or legal representative.

a. When a request without known prior consent is received, the superintendent or designee will not acknowledge the presence or nonpresence of an individual at the facility.

b. If the individual is in the facility, the superintendent or designee will make the individual or the individual's parent, guardian, or legal representative aware of the request. Notice to the individual or the individual's parent, guardian, or legal representative will be documented in the individual's record. The individual or the individual's parent, guardian, or legal representative will be free to decide whether an interview is granted.

This rule is intended to implement Iowa Code sections 217.30 and 218.4.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—28.6(218) Use of grounds, facilities, or equipment.

28.6(1) The superintendent or designee may grant permission for temporary use of assembly halls, auditoriums, meeting rooms, or facility grounds to an organization or group of citizens when the space or grounds are available and are not needed for regularly scheduled departmental services.

28.6(2) Members of outside organizations permitted to use a facility's space or grounds will observe the same rules as visitors to the facility.

This rule is intended to implement Iowa Code chapter 218.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—28.7(218) Tours of facility. Groups or persons will be permitted to tour the facility only with approval of the superintendent or designee.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—28.8(218) Donations. Donations of money, clothing, books, games, recreational equipment or other gifts will be made directly to the superintendent or designee. The superintendent or designee will evaluate the donation in terms of the nature of the contribution to the facility's program. The superintendent or designee will be responsible for accepting the donation and reporting the gift to the department. All monetary gifts will be acknowledged in writing to the donor.

This rule is intended to implement Iowa Code chapter 218.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—28.9(217) Release of confidential information. Information defined by statute as confidential concerning individuals who currently receive or formerly received services from the mental health institutes or resource center shall not be released to a person, agency or organization that is not authorized by law to have access to the information unless the individual, parent, guardian, or legal representative authorizes the release. Authorization will be given by using an Authorization to Obtain or Release Health Care Information form provided by the department.

This rule is intended to implement Iowa Code section 217.30.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

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CHAPTER 29
MENTAL HEALTH INSTITUTES

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

441—29.1(218,229) Voluntary admissions.

29.1(1) *Application form.* Any individual who has symptoms of mental illness may apply for voluntary inpatient treatment or voluntary outpatient or day treatment using an application for voluntary admission to a mental health institute from the department's website.

29.1(2) *Minors.* A parent, guardian, or legal representative of a minor individual may make application for the individual's voluntary admission directly to the mental health institute using an application for voluntary admission to a mental health institute form. When a minor objects to the admission and the chief medical officer of the mental health institute determines that the admission is appropriate, the parent, guardian, or custodian must petition the juvenile court for approval of admission before the minor will be admitted.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—29.2(229) Authorization for treatment. No individual receiving services, either on a voluntary or involuntary basis, will be provided treatment other than what is necessary to preserve life or protect others from physical injury unless:

1. The individual has given consent by signing a mental health institute agreement and consent to treatment form;
2. A court has ordered treatment; or
3. The individual's parent, guardian, or legal representative has given consent by signing a mental health institute agreement and consent to treatment form.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—29.3(217,228,229) Rights of individuals. An individual receiving care from a state mental health institute will have the following rights.

29.3(1) *Information.* An individual receiving care from a state mental health institute will have the right to:

a. Receive an explanation and written copy of the rules of the facility.

b. Be provided information on the provisions of law pertaining to admission to and discharge from the facility.

c. Receive an explanation of the individual's medical condition and be informed of treatment plans and the attendant risks of treatment.

d. Be provided with complete and current information concerning the individual's diagnosis, treatment, and progress in terms and language understandable to the individual.

e. Have the information required in this subrule made available to the individual's parent, guardian, or legal representative when it is not feasible to give the information directly to the individual.

29.3(2) *Care and treatment.* An individual receiving care from a state mental health institute will have the right to:

a. Be evaluated promptly following admission and receive emergency services appropriate to the individual's needs.

b. Have a current individualized written plan of treatment.

c. Receive appropriate treatment, services, and rehabilitation for the individual's mental illness, including appropriate and sufficient medical and dental care.

d. Have the opportunity for educational, vocational, rehabilitative, and recreational programs appropriate to the individual's treatment needs.

e. Have the confidentiality of the individual's personal mental health institute records maintained and have access to those records within a reasonable period.

f. Have an individualized posthospitalization plan.

29.3(3) *Living conditions.* An individual receiving care from a state mental health institute will have the right to:

a. Live in the least restrictive conditions necessary to achieve the purposes of treatment.

b. Receive care in a manner that respects and maintains the individual's dignity and individuality.

c. Have opportunities for personal privacy, including during the care of personal needs.

d. Keep and use appropriate personal possessions, including wearing the individual's own clothing.

e. Be free from unnecessary drugs, restraints, and seclusion except when necessary to protect the immediate health or safety of the individual or others.

f. Be free from physical, psychological, sexual, or verbal abuse; neglect; and exploitation.

29.3(4) *Communication.* An individual receiving care from a state mental health institute will have the right to:

a. Have a family contact or representative of the individual's choice or the individual's community physician notified promptly of the individual's admission.

b. Communicate with people and access services at the facility and in the community, including organizing and participating in resident groups while at the facility.

c. Receive visits of the individual's choice from parents, guardians, legal representatives, or family without prior notice given to the facility unless the visits have been determined inappropriate by the individual's treatment team.

d. Communicate and meet privately with persons of the individual's choice without prior notice given to the facility unless the communication is determined inappropriate by the individual's treatment team.

e. Send and receive unopened mail.

f. Make and receive private telephone calls unless the calls have been determined inappropriate by the individual's treatment team.

g. Access current informational and recreational media, such as newspapers, television, or periodicals.

29.3(5) *Self-determination.* An individual receiving care from a state mental health institute will have the right to:

a. Have a dignified existence with self-determination, making choices about aspects of the individual's life that are significant to the individual.

b. Participate in the development and implementation of the individual's treatment plan.

c. Give informed consent, including the right to withdraw consent at any given time.

d. Refuse treatment (such as medication, surgery or electroconvulsive therapy) offered without the individual's expressed informed consent and be provided with an explanation of the consequences of those refusals unless treatment is necessary to protect the health or safety of the individual or is ordered by a court.

e. Immediate discharge (if admitted voluntarily) by submitting a written notice to the superintendent or chief medical officer unless a written request for involuntary hospitalization is submitted to a court.

f. Refuse to perform services for the facility and not be coerced to perform services.

g. Manage the individual's own financial affairs unless doing so is limited under law or determined not appropriate by the individual's treatment team.

h. Choose activities, schedules, and care consistent with the individual's interests, needs, and treatment plans.

i. Engage in social, religious, and community activities of the individual's choice.

j. Formulate advanced directives and be provided care in compliance with these directives.

29.3(6) *Advocacy.* An individual receiving care from a state mental health institute will have the right to:

a. Exercise the individual's rights as a citizen or resident of the United States.

b. File a grievance pursuant to rule 441—28.3(229) without any intimidation or reprisal resulting from the grievance.

c. Request a judicial review of the hospitalization, file for a writ of habeas corpus, have an attorney of the individual's choice, and communicate and meet privately with the individual's attorney without prior notice given to the facility.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—29.4(218) Visiting.

29.4(1) Visiting hours will be posted in each facility. The physician may designate exceptions for special hours on an individual or ward basis. Therapy for the individual will take precedence over visiting. Visiting will not interfere with the individual's treatment program or meals.

29.4(2) A visit will be terminated when behavior on the part of the individual or visitor is disruptive to the individual's treatment plan.

29.4(3) Visiting on grounds will be permitted when the individual has a grounds pass.

29.4(4) Visitors wishing to take an individual off grounds will receive prior approval from the attending physician.

29.4(5) All visitors will obtain a visitor's pass at the switchboard or another area as designated by the superintendent and posted. The pass will be given to a ward employee before the visitor is allowed on the ward.

29.4(6) Persons under 12 years of age shall not visit on the ward.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code chapters 217, 218, 228, 229, and 230.

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CHAPTER 30
STATE RESOURCE CENTER

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

441—30.1(218,222) Admission. Express written consent of the individual or the individual's parent, guardian, or legal representative shall be secured before admission.

30.1(1) *Application.*

a. Applications for the care, treatment, or evaluation of an individual by a resource center shall be made to the department.

b. The application shall be made using the form for application for admission to a state resource center and shall be accompanied by:

(1) A completed resource center agreement and consent for services form, and

(2) Other information specifically requested in writing by the resource center.

30.1(2) *Application for readmission.* When the application is for a readmission, the resource center may waive the resubmittal of any information already in the files other than the form for application for admission to a state resource center.

30.1(3) *Receipt of application.* Upon receipt of an application, the resource center may:

a. Provide an individual with outpatient evaluation treatment, training, or habilitation services; or

b. Admit an individual on a temporary basis for either:

(1) A preadmission diagnostic evaluation to determine whether the individual would be appropriate to admit to the regular program, or

(2) A diagnostic evaluation to assist in planning for community-based services or respite care.

30.1(4) *Eligibility for admission.* Eligibility for admission will be determined by:

a. A preadmission diagnostic evaluation,

b. An established diagnosis of intellectual disability,

c. The availability of an appropriate program, and

d. The availability of space at the facility.

This rule is intended to implement Iowa Code sections 222.13 and 222.13A.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—30.2(222) Liability for support. The liability of any person, other than the individual, who is legally bound for the support of any individual under 18 years of age will be determined in the same manner as parent liability in rule 441—156.2(234), except that the maximum liability will not exceed the standards for personal allowances established by the department under the family investment program.

This rule is intended to implement Iowa Code section 222.78.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—30.3(217,218) Rights of individuals.

30.3(1) *Information.* An individual receiving care from a state resource center has the right to:

a. Receive an explanation and written copy of the rules of the facility.

b. Receive an explanation of the individual's medical condition, developmental status, and behavioral status, and be informed of treatment plans and the attendant risks of treatment.

30.3(2) *Care and treatment.* An individual receiving care from a state resource center has the right to:

a. Receive appropriate treatment, services, and habilitation for the individual's disabilities, including appropriate and sufficient medical and dental care.

b. Have the confidentiality of the individual's personal resource center records maintained and have access to those records within a reasonable period.

c. Work, when available and desired and as appropriate to the individual's plan of treatment, and be compensated for that work in accordance with federal and state laws.

30.3(3) *Living conditions.* An individual receiving care from a state resource center has the right to:

a. Receive care in a manner that respects and maintains the individual's dignity and individuality.

b. Have opportunities for personal privacy, including during the care of personal needs.

c. Keep and use appropriate personal possessions, including wearing the individual's own clothing.

d. Share a room with a spouse when both live in the same facility.

e. Be free from unnecessary drugs and restraints.

f. Be free from physical, psychological, sexual, or verbal abuse; neglect; and exploitation.

30.3(4) *Communication.* An individual receiving care from a state resource center has the right to:

a. Communicate with people and access services at the facility and in the community, including organizing and participating in resident groups while at the facility.

b. Receive visits of the individual's choice from parents, guardians, legal representatives, or family without prior notice given to the facility unless the visits have been determined inappropriate by the individual's treatment team.

c. Communicate and meet privately with persons of the individual's choice without prior notice given to the facility unless the communication is determined inappropriate by the individual's treatment team.

d. Send and receive unopened mail.

e. Make and receive private telephone calls unless the calls have been determined inappropriate by the individual's treatment team.

30.3(5) *Self-determination.* An individual receiving care from a state resource center has the right to:

a. Have a dignified existence with self-determination, making choices about aspects of the individual's life that are significant to the individual.

b. Give informed consent, including the right to withdraw consent at any given time.

c. Refuse treatment (such as medication or behavioral interventions) offered without the individual's expressed informed consent and be provided with an explanation of the consequences of those refusals unless treatment is necessary to protect the health or safety of the individual or is ordered by a court.

d. Refuse to perform services for the facility and not be coerced to perform services.

e. Manage the individual's own financial affairs unless doing so is limited under law or determined not appropriate by the individual's treatment team.

f. Choose activities, schedules, and care consistent with the individual's interests, needs and care plans.

g. Engage in social, religious, and community activities of the individual's choice.

30.3(6) *Advocacy.* An individual receiving care from a state resource center has the right to:

a. Exercise the individual's rights as a citizen or resident of the United States.

b. File a grievance pursuant to rule 441—28.3(229) without any intimidation or reprisal resulting from the grievance.

This rule is intended to implement Iowa Code sections 217.30 and 218.4.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

441—30.4(218) Visiting.

30.4(1) Individuals are encouraged to and will be able to receive visits from persons of the individual's choice and at times desired by the individual. At the individual's choice, the individual's parents, guardian, or legal representative or other members of the individual's family may visit without prior notice given to the facility.

30.4(2) Visits determined to be inappropriate or disruptive to the individual's treatment plan or the health and safety of other individuals may be denied or terminated.

30.4(3) An individual or other person denied visitation may file a grievance through the facility's grievance process.

This rule is intended to implement Iowa Code chapter 218.

[**ARC 9275C**, IAB 5/14/25, effective 7/1/25]

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CHAPTER 31
CIVIL COMMITMENT UNIT FOR SEXUAL OFFENDERS

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441—31.1(229A) Definitions.

"Contraband" means weapons; ammunition; tobacco; alcohol; drugs; money; altered authorized property; mood-altering plant materials or chemicals; obscene materials as defined in Iowa Code section 728.1(5); explosives; materials that can be used in the manufacture of explosives; or materials advocating disruption of or injury to patients, employees, programs, or physical facilities. "Contraband" includes anything that is illegal to possess under federal or state law and materials that are used in the production of drugs or alcohol or used in conjunction with the taking of illicit drugs. "Contraband" also includes anything determined to be banned from individual possession by published facility rules.

"Facility" means the civil commitment unit for sexual offenders (CCUSO).

"Grievance" means a written complaint by or on behalf of a patient that involves a rights or rule violation or unfairness to the patient.

"Guardian" means the person other than a parent of a child who has been appointed by the court to have custody of the person of the patient as provided under Iowa Code section 232.2(26) or 633.3(22).

"Institutional superintendent" means the person appointed as the administrator of CCUSO.

"Patient" means a person who has been determined to be a sexually violent predator and civilly committed to CCUSO under Iowa Code chapter 229A.

[**ARC 0592D**, IAB 9/16/26, effective 11/1/26]

441—31.2(229A) Visitation. CCUSO will maintain policies and procedures for visitation for patients.

[**ARC 0592D**, IAB 9/16/26, effective 11/1/26]

441—31.3(229A) Grievances. CCUSO will maintain policies and procedures for patients to file a grievance. A patient's family or guardian may file a grievance on the patient's behalf.

[**ARC 0592D**, IAB 9/16/26, effective 11/1/26]

441—31.4(229A) Photographing and recording patients. CCUSO will utilize video surveillance for security and investigations. Photographing and video and audio recording of patients for any other purpose are subject to CCUSO's policies and procedures for prior authorization.

[**ARC 0592D**, IAB 9/16/26, effective 11/1/26]

441—31.5(229A) Public media. Photographs and video and audio recordings by public media inside the facility and of patients will be permitted only with the prior authorization of the institutional superintendent and of the patient or the patient's guardian.

31.5(1) For the security or confidentiality of other patients, the institutional superintendent may limit the scope of what is photographed or recorded.

31.5(2) Public media representatives authorized to take photographs or recordings shall make every effort to preserve the inherent dignity of the patient and to preclude the exploitation or embarrassment of the patient.

[**ARC 0592D**, IAB 9/16/26, effective 11/1/26]

441—31.6(229A) Communication with patients.

31.6(1) *Incoming telephone calls.* CCUSO does not allow patients to receive incoming telephone calls.

31.6(2) *Outgoing telephone calls.* CCUSO will maintain policies and procedures for patients to make outgoing telephone calls.

31.6(3) *Attorney contacts.* A patient's attorney shall have the right to visit or have telephone contact with the patient at any reasonable time. The patient shall have the right to call the individual's attorney during normal business hours and at other times with the consent of the attorney. The patient or the attorney shall be responsible for any costs associated with the call.

31.6(4) *Interviews.* Interviews of a patient by the news media or other outside persons or groups shall be permitted only with the prior consent of the patient or the patient's guardian. Requests for interviews shall be made to the institutional superintendent.

31.6(5) *Mail and packages.* CCUSO will maintain policies and procedures for incoming and outgoing mail, including a policy that correspondence is not permitted between a patient and a patient's victim, a registered sex offender, or another patient residing at CCUSO. Should mail or packages be rejected by the facility for any reason, such as containing contraband, being a security risk, or being counter-therapeutic, notice will be provided to the sender and the recipient via the CCUSO form Notice of Rejection of Mail within two business days.

[**ARC 0592D**, IAB 9/16/26, effective 11/1/26]

441—31.7(229A) Building and grounds. The facility's building and grounds are not available for general public use.

[**ARC 0592D**, IAB 9/16/26, effective 11/1/26]

441—31.8(229A) Cost of care. The facility will seek to recover the full cost or a portion of the cost of care from the patient or another responsible person. The cost of the patient's care will be determined for each fiscal year included in the length of stay using the average per diem cost multiplied by the total number of days of care.

31.8(1) *Social security benefits.* The facility will seek recovery from the patient when the patient receives a benefit pursuant to the Social Security Act as amended to August 1, 2026. In such case, the patient will be allowed to retain for personal use an amount equal to the personal allowance amount established by the Social Security Administration.

31.8(2) *Other income.* The facility will seek recovery from the patient when the patient has other income; a trust fund; individually owned real estate, stocks, or bonds; an individually owned savings account, checking account, or certificate of deposit; an individual retirement account; or proceeds from the disposal of real estate or other property.

31.8(3) *Other person legally liable.* The facility will seek recovery from a person who is legally liable for the support of the patient up to the amount of the person's legal liability. The facility will seek recovery from a person who is bound by contract to support the patient up to the amount of the contract. A person legally liable to support the patient does not include a political subdivision.

[**ARC 0592D**, IAB 9/16/26, effective 11/1/26]

These rules are intended to implement Iowa Code section 229A.15B.

[Filed ARC 9646B (Notice ARC 9481B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]
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[Filed ARC 0592D (Notice ARC 0410D, IAB 7/8/26), IAB 9/16/26, effective 11/1/26]

CHAPTER 32
STATE COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION SERVICES FUND AND SPECIAL NEEDS GRANTS
[Prior to 7/1/83, Social Services[770] Ch 32]
[Prior to 2/11/87, Human Services[498]]
Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 33
COMMUNITY MENTAL HEALTH CENTER STANDARDS
Rescinded 9/29/93 IAB, effective 12/1/93; see 441—Chapter 24, Divisions I, III.

CHAPTER 34
ALTERNATIVE DIAGNOSTIC FACILITIES
[Prior to 8/18/82, Mental Health Advisory Council[566] Ch 2]
[Prior to 7/1/83, Social Services[770] Ch 34]
[Prior to 2/11/87, Human Services[498]]
Rescinded **ARC 9274C**, IAB 5/14/25, effective 7/1/25

CHAPTER 35
SUPPLEMENTAL EXPENSE PAYMENT
Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 36
FACILITY ASSESSMENTS

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

441—36.1(249A) Intermediate care facilities for persons with an intellectual disability assessment. Intermediate care facilities for persons with an intellectual disability (ICFs/ID) licensed in Iowa under 481—Chapter 64, including facilities not certified to participate in the Medicaid program, shall pay a quarterly fee to the department. The fee equals 5.5 percent of actual paid claims, from all sources, for the facility's preceding quarter.

[**ARC 9064C**, IAB 4/2/25, effective 6/1/25]

441—36.2(249A) Determination and payment of fee. For all ICFs/ID licensed in Iowa under 481—Chapter 64, including facilities not certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.2(1) Each facility shall pay the assessment to the department on a quarterly basis. The facility shall:

a. Use a form prescribed by the department to calculate the quarterly fee due.

b. Submit the form and the quarterly fee no later than 30 days following the end of each calendar quarter.

36.2(2) The facility shall calculate the amount of the quarterly fee due by multiplying 5.5 percent by the facility's total ICF/ID payments for services received from all sources during the preceding quarter, including but not limited to:

a. Medicaid managed care payments.

b. Client participation payments.

c. Medicaid fee-for-service payments.

d. Private pay/insurance payments.

e. Ancillary service payments.

36.2(3) If the department determines that an ICF/ID has underpaid or overpaid the fee, the department will notify the ICF/ID of the amount of the unpaid fee or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.2(4) An ICF/ID that fails to pay the fee within 30 days of the issuance of the notice shall pay a penalty in the amount of 1.5 percent of the unpaid fee due for each month or portion of a month that the unpaid fee is overdue.

a. If the ICF/ID substantiates good cause beyond the facility's control for failure to make timely payment of the fee, the department will waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" means the same as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

b. Requests for a good cause waiver must be submitted to the department within 30 days of notice to the facility that the penalty is due.

[**ARC 9064C**, IAB 4/2/25, effective 6/1/25]

441—36.3(249L) Nursing facility assessment.

36.3(1) *Applicability.* All nursing facilities as defined in Iowa Code section 135C.1 that are free-standing facilities or are operated by a hospital licensed pursuant to Iowa Code chapter 135B shall pay a quarterly assessment to the department, as determined under these rules, with the exception of:

a. Nursing facilities operated by the state.

b. Non-state government-owned or government-operated nursing facilities.

c. Distinct-part skilled nursing units and swing-bed units operated by a hospital.

36.3(2) *Assessment level.*

a. Effective April 1, 2023, nursing facilities with 46 or fewer licensed beds are required to pay a quality assurance assessment of $6.51 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2021, the number of licensed beds on file with the department of inspections,

appeals, and licensing as of June 1 of each year shall be used to determine the assessment level for the following state fiscal year.

b. Effective July 1, 2024, nursing facilities designated as continuing care retirement centers (CCRCs) by the insurance division of the department of insurance and financial services are required to pay a quality assurance assessment of $6.51 per non-Medicare patient day. Effective with the assessment for the state fiscal year beginning July 1, 2021, continuing care retirement center designations as of June 1 of each year shall be used to determine the assessment level for the following state fiscal year.

c. Effective April 1, 2023, nursing facilities with annual Iowa Medicaid patient days of 19,000 or more are required to pay a quality assurance assessment of $6.51 per non-Medicare patient day. Effective with assessment for the state fiscal year beginning July 1, 2021, the annual number of Iowa Medicaid patient days reported in the most current cost report submitted to the department as of June 1 of each year shall be used to determine the assessment level for the following state fiscal year.

d. Effective April 1, 2023, all other nursing facilities are required to pay a quality assurance assessment of $33.90 per non-Medicare patient day.

[**ARC 9064C**, IAB 4/2/25, effective 6/1/25]

441—36.4(249L) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.4(1) Each nursing facility shall pay the quality assurance assessment to the department on a quarterly basis. The facility shall:

a. Use the form prescribed by the department to calculate the quarterly assessment amount due.

b. Submit the form and the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.4(2) The facility shall calculate the amount of the quarterly assessment due by multiplying the facility's total non-Medicare patient days for the preceding quarter by the applicable assessment level as determined in subrule 36.6(2).

36.4(3) If the department determines that a nursing facility has underpaid or overpaid the quality assurance assessment, the department will notify the nursing facility of the amount of the unpaid quality assurance assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.4(4) A nursing facility that fails to pay the quality assurance assessment within 30 days of the issuance of the notice will pay a penalty in the amount of 1.5 percent of the quality assurance assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the facility substantiates good cause beyond the facility's control for failure to comply with payment of the quality assurance assessment, the department will waive the penalty or a portion of the penalty. For purposes of this subrule, "good cause" means the same as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

b. Requests for a good cause waiver must be submitted to the department within 30 days of notice to the facility that the penalty is due.

[**ARC 9064C**, IAB 4/2/25, effective 6/1/25]

441—36.5(249M) Participating hospital assessment.

36.5(1) *Participating hospitals.* For the purpose of the health care access assessment program, a "participating hospital" is defined as a non-state-owned hospital licensed under Iowa Code chapter 135B that is paid on a prospective payment system basis by Medicare and the medical assistance programs for inpatient and outpatient services.

36.5(2) *Assessment.* Participating hospitals are required to pay a quarterly health care access assessment equal to 1.26 percent of net patient revenue as specified in the hospital's fiscal year 2008 Medicare cost report. "Net patient revenue" means all revenue reported for acute patient care and services but does not include:

a. Contractual adjustments,

b. Charity care,

c. Bad debt,

d. Medicare revenue, or

e. Other revenue derived from sources other than hospital operations, including but not limited to:

(1) Nonoperating revenue,

(2) Other operating revenue,

(3) Skilled nursing facility revenue,

(4) Physician revenue, and

(5) Long-term care revenue.

[**ARC 9064C**, IAB 4/2/25, effective 6/1/25]

441—36.6(249M) Determination and payment of assessment. The assessment shall be determined and paid as follows:

36.6(1) The department will calculate the annual amount of the health care access assessment as 1.26 percent of net patient revenue as specified in the participating hospital's fiscal year 2008 Medicare cost report. The annual amount will be divided by four to calculate the quarterly amount.

36.6(2) Each participating hospital shall pay the health care access assessment to the department on a quarterly basis. The hospital shall submit the quarterly assessment payment no later than 30 days following the end of each calendar quarter.

36.6(3) A participating hospital shall retain and preserve the Medicare cost report and financial statements used to prepare the cost report in accordance with Iowa Code section 249M.3.

36.6(4) If the department determines that a participating hospital has underpaid or overpaid the health care access assessment, the department will notify the hospital of the amount of the unpaid health care access assessment or refund due. Such amount shall be due or refunded within 30 days of the issuance of the notice.

36.6(5) A participating hospital that fails to pay the health care access assessment within 30 days of the issuance of the notice will pay a penalty in the amount of 1.5 percent of the health care access assessment amount owed for each month or portion of a month that the payment is overdue.

a. If the department determines that good cause is shown for failure to comply with payment of the health care access assessment, the department will waive the penalty or a portion of the penalty.

b. Requests for a good cause waiver must be submitted to the department within 30 days of notice to the facility that the penalty is due.

[**ARC 9064C**, IAB 4/2/25, effective 6/1/25]

These rules are intended to implement Iowa Code chapters 249A, 249L, and 249M.

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CHAPTER 37
STANDARDS FOR THE CARE OF AND SERVICES TO COUNTY CARE FACILITY RESIDENTS WITH MENTAL ILLNESS AND MENTAL RETARDATION

Rescinded IAB 5/5/99, effective 7/1/99

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

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

441—38.1(217,42USC144) Administering agency. Pursuant to the DD Act, the department has been designated as the administering agency to receive the federal assistance to the state developmental disabilities councils from the federal Administration for Community Living. These funds are used by the Iowa DD council.
[**ARC 0347D**, IAB 6/10/26, effective 8/1/26]

441—38.2(217,42USC144) Definitions.

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

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

"Iowa DD council" means the Iowa developmental disabilities council.

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

"State plan" means the document required under the DD Act that describes goals, objectives and funding priorities.
[**ARC 0347D**, IAB 6/10/26, effective 8/1/26]

441—38.3(217,42USC144) Program eligibility. For any year in which Congress appropriates funds, the Iowa DD council shall, consistent with the state plan and the priorities established under the DD Act, determine projects to fund under the developmental disabilities basic state grant program. Funding priorities will be established by the Iowa DD council in the state plan and will be consistent with the priorities established in the DD Act. (Applications for capital expenditures or capital renovations are not eligible for funding.) The Iowa DD council may award funding through any of the department-approved processes for competitive, sole source, or unsolicited proposals in accordance with the provisions of 11—Chapter 117 for the procurement of goods and services of general use.
[**ARC 0347D**, IAB 6/10/26, effective 8/1/26]

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

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

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

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

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

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CHAPTER 39
MENTAL ILLNESS SPECIAL SERVICES FUND
Rescinded IAB 10/15/03, effective 12/1/03

TITLE IV
FAMILY INVESTMENT PROGRAM

CHAPTER 40
APPLICATION FOR AID

[Prior to 7/1/83, Social Services[770] Ch 40]
[Prior to 2/11/87, Human Services[498]]
[Rescinded IAB 2/12/97, effective 3/1/97]

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

441—40.1 to **40.20** Reserved.

441—40.21(239B) Definitions.

"Applicant" means a person for whom assistance is being requested, parent(s) living in the home with the child(ren), and the nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child(ren).

"Assistance unit" includes any person whose income is considered when determining eligibility or the family investment program grant amount.

"Casino, gambling casino, or gaming establishment" means an establishment with a primary purpose of accommodating the wagering of money. It does not include:

1. A grocery store that sells groceries including staple foods and that also offers, or is located within the same building or complex as, casino, gambling, or gaming activities; or
2. Any other establishment that offers casino, gambling, or gaming activities incidental to the principal purpose of the business.

An automated teller machine (ATM) or a point-of-sale (POS) terminal located within those areas of an establishment where individuals are banned due to age restrictions associated with gambling, established by state or federal law or by any other regulatory entity having the authority to do so, is considered to be in a casino, gambling casino, or gaming establishment.

"Central office" means the state administrative office of the department.

"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.

"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 family investment program.

"Electronic benefit transfer transaction" means the use of a credit or debit card service, automated teller machine, point-of-sale terminal, or access to an online system for the withdrawal of funds or the processing of a payment for merchandise or a service.

"Income in kind" is any gain or benefit that is not in the form of money payable directly to the eligible group including nonmonetary or in-kind benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments that are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which assistance is paid. This may include a month for which a partial payment is made.

"Liquor store" means any retail establishment that sells exclusively or primarily intoxicating liquor or other alcoholic beverages. Such term does not include a grocery store that sells both intoxicating liquor and groceries including staple foods (within the meaning of Section 3(r) of the Food and Nutrition Act of 2008 (7 U.S.C. §2012(r)) as amended to December 31, 2024).

Unless exempt as described in this definition, a retail establishment meets the definition of a liquor store when it has a North American Industry Classification System (NAICS) number that categorizes the retail establishment as either a beer, wine and liquor store or as a drinking place (alcoholic beverages). A retail establishment that does not have either type of NAICS code is considered to exclusively or primarily sell intoxicating liquor when 95 percent or more of the retail establishment's gross sales are from

intoxicating liquor and it is not a United States Department of Agriculture-certified Supplemental Nutrition Assistance Program (SNAP) retailer.

"Medical institution," as used in this title, means a facility that 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 441—subrule 41.22(3), who meets all the eligibility requirements to be included in the family investment program.

"Parent" means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

"Payment month" means the calendar month for which assistance is paid.

"Payment standard" means the total needs of a group as determined by adding need according to the schedule of basic needs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

"Promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program" means the department's work and training program as described in 441—Chapter 93.

"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 that will exist in that calendar month.

"Qualified alien" means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA) as amended to December 31, 2024;
2. Who is granted asylum in the United States under Section 208 of the INA as amended to December 31, 2024;
3. Who is a refugee admitted to the United States under Section 207 of the INA as amended to December 31, 2024;
4. Who is paroled into the United States under Section 212(d)(5) of the INA as amended to December 31, 2024, for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is admitted to the United States as an Amerasian as described in 8 U.S.C. §1612(b)(2)(A)(ii)(V) as amended to December 31, 2024;
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. §1641(b)(7) as amended to December 31, 2024;
9. Who is a battered alien as described in 8 U.S.C. §1641(c) as amended to December 31, 2024; or
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

"Qualifying quarters" means all of the qualifying quarters of coverage as defined under Title II of the Social Security Act as amended to December 31, 2024, that were worked by a parent of an alien while the alien was under the age of 18 and all of the qualifying quarters that were 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.

"Recipient" means a person for whom assistance is paid, parent(s) living in the home with the eligible child(ren) and nonparental relative as defined in 441—subrule 41.22(3) who is receiving assistance for the child(ren). 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.

"Retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment" means an establishment that includes live entertainment at locations such as but not limited to strip clubs and gentlemen's clubs. It also includes stores and theaters that exclusively or primarily sell or feature adult-oriented videos and movies such as but not limited to adult book stores and adult movie theaters. A retail establishment meets this definition when the department has confirmed the primary nature of the business through the description on the business's website, phone contact with the establishment, a site visit, or other means such as common local knowledge.

"Standard of need" means the total needs of a group as determined by adding need according to the schedule of living costs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

"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" will include an unborn child during the entire term of the pregnancy.

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

441—40.22(239B) Application. The application for the family investment program shall be submitted on an application form prescribed by the department. The application shall be signed by the applicant, the applicant's authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf. When both parents, or a parent and a stepparent, are in the home and eligibility is determined on a family or household basis, one parent or stepparent may sign the application and attest to the information for the assistance unit.

40.22(1) Each individual wishing to do so will have the opportunity to apply for assistance without delay. When the parent is in the home with the child and is not prevented from acting as payee by reason of physical or mental impairment, this parent shall make the application.

40.22(2) An applicant may be assisted by other individuals in the application process; the client may be accompanied by such individuals in contact with the department, and when so accompanied, may also be represented by them. When the applicant has a guardian, the guardian shall participate in the application process.

40.22(3) The applicant shall immediately be given an application form to complete. When the applicant requests that the form be mailed, the department will send the necessary forms in the next outgoing mail.

40.22(4) A new application is not required when adding a new person to the eligible group or when a parent or a stepparent becomes a member of the household.

40.22(5) Reinstatement.

a. Assistance will be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished, or the family meets the conditions described in 441—subparagraph 41.30(3)*"f"*(9). Exception: The reinstatement provisions of subrule 40.22(5) do not apply when assistance is canceled due to the imposition of a subsequent limited benefit plan as described in 441—subrule 41.24(8) unless the limited benefit plan is stopped as described in 441—paragraph 41.24(8)*"g"* or *"h."*

b. When assistance has been canceled for failure to provide requested information, assistance will be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date all information required to establish eligibility is provided.

c. When assistance has been canceled for failure to return a completed review form pursuant to subrule 40.27(3), assistance will be reinstated without a new application if the completed form is received

by the department within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date the review form prescribed by the department is received.

d. When assistance has been canceled for failure to complete a required review interview, assistance will be reinstated without a new application if the interview is completed and all necessary information to determine eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility is reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date the interview is completed.

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

441—40.23(239B) Date of application. The date of application is the date the application form prescribed by the department is received by the department. 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.

40.23(1) The date of application is also the date an identifiable application is received by a designated worker who is in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The hospital, health center or other facility will forward the application to the department office that is responsible for the completion of the eligibility determination.

40.23(2) An identifiable application is an application containing a legible name and address that has been signed.

40.23(3) A new application is not required when adding a person to an existing eligible group. This person is considered to be included in the application that established the existing eligible group. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person will be the date of the report.

a. In those instances where a person previously excluded from the eligible group as described in 441—subrule 41.27(11) is to be added to the eligible group, the date of application to add the person is the date the person indicated willingness to cooperate.

b. Exceptions:

(1) When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the date of application to add the person is the date the social security number or proof of application for a social security number is provided.

(2) When adding a person who was previously excluded from the eligible group as described in 441—subrule 41.23(5), 441—subrule 41.25(5), or rule 441—46.29(239B), the date of application to add the person is the first day after the period of ineligibility has ended.

(3) When adding a person who was previously excluded from the eligible group as described in 441—subrule 41.24(8), the date of application to add the person is the date the person signs a family investment agreement.

40.23(4) Grace period.

a. When an application has been denied for failure to provide requested information, if all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date all of the information is provided.

b. When an application has been denied for failure to attend an interview, if the interview is completed and all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date the interview is completed or the date all of the information is provided, whichever is later.

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

441—40.24(239B) Procedure with application.

40.24(1) The decision with respect to eligibility will be based primarily on information furnished by the applicant.

a. The applicant shall report no later than at the time of the interview any change as defined in paragraph 40.27(4)*"e"* that occurs after the application was signed. Any change that occurs after the interview shall be reported by the applicant within five days from the date the change occurred.

b. The department will notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources will serve as a basis for denial of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

(1) Five working days will be considered as a reasonable period for the applicant to supply the required information or verification. The department will extend the deadline when the applicant requests an extension because the applicant is making every effort to supply the information or verification but is unable to do so.

(2) "Supply" means the requested information is received by the department by the specified due date. Any time taken beyond the required time frame will be considered a delay on the part of the applicant.

c. When an individual is added to an existing eligible group, the five-day requirement for reporting changes will be waived. These individuals and eligible groups will be subject to the recipient's ten-day reporting requirement as defined in subrule 40.27(4).

40.24(2) The department or the designated worker as described in subrule 40.23(1) will conduct a face-to-face or telephone interview with the applicant before approval of the application for assistance.

a. The worker will assist the applicant, when requested, in providing information needed to determine eligibility and the amount of assistance.

b. The application process shall include a visit, or visits, to the home of the child and the person with whom the child will live during the time assistance is granted under the following circumstances:

(1) When it is the judgment of the worker or the supervisor that a home visit is required to clarify or verify information pertaining to the eligibility requirements; or

(2) When the applicant requests a home visit for the purpose of completing a pending application.

c. When adding an individual to an existing eligible group, the interview requirement may be waived.

40.24(3) Reserved.

40.24(4) The decision with respect to eligibility will be based on the applicant's eligibility or ineligibility on the date the department enters all eligibility information into the department's computer system. The applicant shall become a recipient on the date all eligibility information is entered into the department's computer system and the computer system determines the applicant is eligible for aid.

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

441—40.25(239B) Time limit for decision. A determination of approval or denial will be made as soon as possible, but no later than 30 days following the date of filing an application. A written notice of decision will be issued to the applicant the next working day following a determination of eligibility or ineligibility. This time standard shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department. When eligibility is dependent upon the birth of a child, the time limit may be extended while awaiting the birth of the child. When it becomes evident that due to an error on the part of the department, eligibility will not be established within the 30-day limit, the application will be approved pending a determination of eligibility.

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

441—40.26(239B) Effective date of grant. New approvals will be effective as of the date the applicant becomes eligible for assistance, but in no case will the effective date be earlier than seven days following the date of application. When an individual is added to an existing eligible group, the individual will be

added effective as of the date the individual becomes eligible for assistance, but in no case will the effective date be earlier than seven days following the date the change is reported. When it is reported that a person is anticipated to enter the home, the effective date of assistance will be no earlier than the date of entry or seven days following the date of report, whichever is later.

40.26(1) When the change is timely reported as described in subrule 40.27(4), a payment adjustment will be made when indicated. When the individual's presence is not timely reported as described in subrule 40.27(4), excess assistance issued is subject to recovery.

40.26(2) In those instances where a person previously excluded from the eligible group as described in 441—subrule 41.27(11) is to be added to the eligible group, the effective date of eligibility will be seven days following the date the person indicated willingness to cooperate. However, in no instance will the person be added until cooperation has actually occurred.

Exceptions: When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the effective date of eligibility will be seven days following the date that the social security number or proof of application for a social security number is provided.

40.26(3) When adding a person who was previously excluded from the eligible group as described in 441—subrules 41.23(5) and 41.25(5) and rule 441—46.29(239B), the effective date of eligibility will be seven days following the date that the period of ineligibility ended.

40.26(4) When adding a person who was previously excluded from the eligible group as described in 441—subrule 41.24(8), the effective date of eligibility will be seven days following the date the person signs a family investment agreement or the date the person is otherwise eligible, whichever is later. In no case will the effective date be within the six-month ineligibility period of a subsequent limited benefit plan as described in 441—paragraph 41.24(8)*"a."*

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

441—40.27(239B) Continuing eligibility.

40.27(1) Eligibility factors will be reviewed at least every six months for the family investment program. An interview may be conducted at the time of a review.

40.27(2) A redetermination of specific eligibility factors will be made when:

a. The recipient reports a change in circumstances.

b. A change in the recipient's circumstances comes to the attention of a staff member.

40.27(3) Information for semiannual reviews shall be submitted on a review form prescribed by the department.

a. The department will supply the review form to the recipient as needed or upon request. The department will pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the department by the seventh day after the date it is mailed by the department.

(3) A copy of a review form received by fax or electronically will have the same effect as an original form.

b. When the client has completed the application form prescribed by the department for another purpose, this form may be used as the review document.

c. The review form shall be signed by the payee, the payee's authorized representative, or, when the payee is incompetent or incapacitated, someone acting responsibly on the payee's behalf.

40.27(4) Responsibilities of recipients. For the purposes of this subrule, recipients shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility and the amount of the family investment program grant.

b. The recipient shall complete the required review form when requested by the department in accordance with subrule 40.27(3). Failure to return a completed form will result in cancellation of assistance. A completed form is a form with all items answered, signed, dated and accompanied by verification as required in 441—paragraphs 41.27(1)*"i"* and 41.27(2)*"h."*

c. The recipient has the primary responsibility for providing information and verification needed to establish eligibility and the amount of the family investment program grant. The recipient shall supply, insofar as the recipient is able, information and verification needed within ten working days from the date a written request is mailed by the department to the recipient's current mailing address or given to the recipient. The department will extend the deadline when the recipient requests an extension because the recipient is making every effort to supply the information or verification but is unable to do so.

(1) "Supply" means that the requested information or verification is received by the department by the specified due date.

(2) When the recipient is unable to furnish information or verification needed to establish eligibility and the amount of the family investment program grant, the recipient shall request assistance from the department.

(3) Failure to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources will serve as a basis for cancellation of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

d. The recipient or applicant shall cooperate with the department when the recipient's or applicant's case is selected by quality control for verification of eligibility. The recipient or applicant shall also cooperate with the front end investigations conducted by the department of inspections, appeals, and licensing to determine whether information supplied to the department by the client is complete and correct regarding pertinent public assistance information unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect family investment program eligibility (more information can be found in 481—Chapter 72). Failure to cooperate will serve as a basis for cancellation or denial of the family's assistance. Once denied or canceled for failure to cooperate, the family may reapply but will not be considered for approval until cooperation occurs.

e. The recipient, or an individual being added to the existing eligible group, shall timely report any change in the following circumstances:

(1) Beginning or ending income, including receipt of a nonrecurring lump sum.

(2) Resources.

(3) Members of the household.

(4) School attendance of a child.

(5) Mailing or living address.

(6) Receipt of a social security number.

f. A report will be considered timely when made within ten days from:

(1) The receipt of resources or income or the date income ended.

(2) The date the address changes.

(3) The date the child is officially dropped from the school rolls.

(4) The date a person enters or leaves the household.

(5) The receipt of a social security number.

g. When a change is not timely reported, any excess assistance paid will be subject to recovery.

40.27(5) After assistance has been approved, eligibility for continuing assistance and the amount of the grant will be effective as of the first of each month. Any change affecting eligibility or benefits reported during a month will be effective the first day of the next calendar month except as follows:

a. When the recipient reports a new person to be added to the eligible group and that person meets eligibility requirements, a payment adjustment will be made for the month of the report, subject to the effective date of grant limitations prescribed in rule 441—40.26(239B).

b. When cancellation of assistance occurs later because issuance of a timely notice, as required by rule 441—16.2(17A), requires that the action be delayed until the first day of the second calendar month, any overpayment received in the first calendar month will be recouped.

c. When the recipient reports a change in income or circumstances timely, as defined in subrule 40.24(1) or 40.27(4), the department will determine prospective eligibility and the grant amount for the following month based on the change.

(1) A payment adjustment will be made when indicated.

(2) Recoupment will be made for any overpayment, with one exception. When a change in income is timely reported by a recipient and timely acted upon by the department, but the timely notice, as required by rule 441—16.2(17A), requires the action be delayed until the second calendar month following the month of change, and eligibility continues, recoupment will not be made.

d. When an individual included in the eligible group becomes ineligible, that individual's needs will be removed prospectively effective the first day of the next calendar month. When the action must be delayed due to administrative requirements, a payment adjustment or recoupment will be made when appropriate.

e. When a sanction under 441—paragraph 41.22(6)*"f"* is implemented, the change will be effective:

(1) The first day of the next calendar month after the change has occurred when the income maintenance unit determines noncooperation; or

(2) After the income maintenance unit receives notification from the child support recovery unit when child support services determines noncooperation.

f. When a sanction under 441—paragraph 41.22(6)*"f"* is removed, the change will be effective the first day of the next calendar month after the recipient has expressed willingness to cooperate, as described in 441—paragraph 41.22(6)*"f."* However, action to remove the sanction will be delayed until:

(1) Cooperation has actually occurred; or

(2) The income maintenance unit has received notification from child support services that the client has cooperated.

g. A different effective date will be applied when specifically indicated in family investment program rules, such as in 441—subrule 41.25(5) and 441—subparagraph 41.27(9)*"c"*(2).

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

441—40.28(239B) Referral for investigation. The department may refer questionable cases to the department of inspections, appeals, and licensing.

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

441—40.29(239B) Alternate payees.

40.29(1) *Conservatorship or guardianship.* When application for the family investment program is filed by a person under conservatorship or guardianship, a copy of the court order will be secured by the department. Assistance payments will be made pursuant to Iowa Code section 239B.13.

40.29(2) *Emergency payee.* Payments may be made to persons acting for relatives who have been receiving assistance for a child in emergency situations that deprive the child of the relatives' care. These payments will be made for a temporary period, not to exceed three months, to allow time to make and implement plans for the child's continuing care and support.

[**ARC 9276C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, 239B.4, 239B.5, 239B.6, 239B.13 and 239B.18.

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CHAPTER 41
GRANTING ASSISTANCE

[Prior to 7/1/83, Social Services[770] Ch 41]
[Prior to 2/11/87, Human Services[498]]
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441—41.1 to **41.20** Reserved.

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

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

41.21(2) Reserved.

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

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

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

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

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

41.22(3) *Specified relationship.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41.22(7) *Assignment of support payments.*

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

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

41.22(8) *Good cause for refusal to cooperate.* Good cause exists when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit will determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical harm to the child for whom support is to be sought; or

(2) Emotional harm to the child for whom support is to be sought; or

(3) Physical harm to the parent or caretaker relative with whom the child is living that reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or caretaker relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

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

(1) The child for whom support is sought was conceived as a result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

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

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

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

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

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

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

a. Before requiring cooperation, the income maintenance unit will notify the applicant or recipient using a form prescribed by the department of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause will:

(1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the FIP.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Corroborate the good cause circumstances.

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

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

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

(1) Be in writing.

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

(3) Be entered in the FIP case record.

b. The determination of whether or not good cause exists will be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 41.22(11).

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

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

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

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

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

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

(2) Consider any recommendation from child support services.

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

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

h. The income maintenance unit will:

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

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

41.22(11) *Proof of good cause.* The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or recipient needs additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit will allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence.

(1) Birth certificates or medical or law enforcement records that indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records that indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records that indicate that the putative father or absent parent might inflict physical or emotional harm on the child or caretaker relative.

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

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

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

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

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

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

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

(1) Advise the applicant or recipient how to obtain the necessary documents, and

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

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

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

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

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

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

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

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

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

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

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

b. The determination will:

(1) Be in writing,

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

(3) Be entered into the FIP case record.

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

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

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

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

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

41.22(14) Reserved.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The present emotional state of the individual subject to emotional harm.
2. The emotional health history of the individual subject to emotional harm.
3. Intensity and probable duration of the emotional impairment.

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

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

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

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

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

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

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

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

(1) Be in writing.

(2) Contain the department's findings and basis for determination.

(3) Be entered in the FIP case record.

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

(1) The applicant or recipient will be so notified.

(2) The application will be denied or FIP assistance canceled.

c. The department will:

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Advise the applicant or recipient how to obtain the necessary documents.

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

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

41.23(1) *Iowa residence.*

a. A resident of Iowa is one:

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

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

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

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

41.23(3) *Absence from the home.*

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

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

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

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

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

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

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

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

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

41.23(5) *Citizenship and alienage.*

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

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

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

1. A qualified alien residing in the United States before August 22, 1996.
2. A battered alien as described in subrule 41.23(4).
3. A qualified alien veteran who has an honorable discharge that is not due to alienage.
4. A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
5. A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in numbered paragraph 41.23(5)*"a"*(2)"3" or *"a"*(2)"4," including a surviving spouse who has not remarried.
6. A refugee admitted under Section 207 of the Immigration and Nationality Act (INA) as amended to December 31, 2024.
7. An alien granted asylum under Section 208 of the INA as amended to December 31, 2024.
8. An alien admitted as an Amerasian as described in 8 U.S.C. Section 1612(a)(2)(A)(ii)(V) as amended to December 31, 2024.
9. A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7) as amended to December 31, 2024.
10. An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA as amended to December 31, 2024.
11. An alien certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 31, 2024.
12. An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. Attestation of status. As a condition of eligibility, an attestation of citizenship or alien status shall be made for all applicants and recipients on an application form, a review form, or another attestation form prescribed by the department. A review form prescribed by the department may be used to attest to the citizenship of dependent children who enter a recipient household. Failure to sign a form attesting to

citizenship when required to do so creates ineligibility for the entire eligible group. The attestation may be signed by:

(1) The applicant;

(2) Someone acting responsibly on the applicant's or recipient's behalf if the applicant or recipient is incompetent or incapacitated; or

(3) Any adult member of the assistance unit, when eligibility is determined on a family or household basis.

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

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

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

a. All persons whose needs are included in a grant under the FIP program.

b. Any parent living in the home of a child receiving a grant.

c. All FIP applicants unless the department determines that the applicant is exempt or does not meet other FIP eligibility requirements.

d. Applicants who have chosen and are in an active limited benefit plan (LBP). FIA-responsible applicants in an active LBP shall complete significant contact with or action in regard to PROMISE JOBS as described in paragraphs 41.24(8)*"d"* and *"e"* for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent is exempt. Exceptions:

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

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

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

a. and *b.* Reserved.

c. A person who is under the age of 16 and is not a parent.

d. A person found eligible for supplemental security income (SSI) benefits based on disability or blindness.

e. A person who is aged 16 to 19, is not a parent, and attends an elementary, a secondary or an equivalent level of vocational or technical school full-time. For persons who lose exempt status for not attending school, once the person has signed an FIA, the person will remain referred to PROMISE JOBS and subject to the terms of the agreement.

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

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

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

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

41.24(3) *Parents aged 19 and under.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41.24(6) Reserved.

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

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

a. An LBP shall either be a first LBP or a subsequent LBP. From the effective date of a first LBP, the FIP-eligible group or individual participant shall not be eligible until the participant who chose the LBP completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8)*"d."* If a subsequent LBP is chosen by the same participant, a six-month period of ineligibility applies to the FIP-eligible group or individual participant and ineligibility continues after the six-month period is over until the participant who chose the LBP completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8)*"e."* An LBP imposed in error as described in paragraph 41.24(8)*"g"* shall not be considered an LBP and shall not count when determining whether a household is subject to a subsequent LBP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Sign a new or updated FIA, and

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

(4) FIP benefits shall not begin until the person who chose the LBP completes the previously defined significant actions. FIP benefits shall be effective the date the FIA is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later, but in no case shall the effective date be within the six-month period of ineligibility.

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

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

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

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

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

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

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

41.24(9) Reserved.

41.24(10) *Notification of services.*

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

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

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

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

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

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

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

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

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

41.25(1) Reserved.

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

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

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

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

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

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

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

41.25(5) *Participation in a strike.*

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

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

c. Definitions:

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

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

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

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

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

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

a. A recipient shall not use the recipient's electronic access card issued pursuant to 441—subrule 45.21(1) to access benefits at any of the following prohibited locations as defined by federal statute or regulation applicable to this prohibition and as further defined in rule 441—40.21(239B):

(1) A liquor store,

(2) A casino, gambling casino, or gaming establishment, or

(3) A retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

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

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

(1) Considered to have committed a fraudulent act;

(2) Liable for any amounts accessed and any associated fees for accessing the benefits at a prohibited location and required to repay such amount in accordance with 441—Chapter 46;

(3) Ineligible for FIP for a three-month period after the first report by DIAL that includes a finding of misuse;

(4) Ineligible for FIP for a six-month period after each subsequent report by DIAL that includes a finding of misuse.

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

(1) DIAL identifies the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow that recipient.

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

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

(1) A recipient files an appeal either:

1. Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or

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

(2) Assistance is continued pending the final decision of the appeal; and

(3) The department's action is affirmed.

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

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

441—41.26(239B) Resources.

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

a. A homestead without regard to its value. A mobile home or similar shelter will be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished will not be considered to have altered the exempt status of the homestead. Except as described in paragraph

41.26(1)*"n"* or *"o"* and paragraph 41.26(6)*"d,"* the net market value of any other real property will be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, that are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

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

d. Motor vehicles.

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

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

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

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

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

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

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

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

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository that is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value that exceeds the exemption will be considered in computing whether the eligible group's property is within the reserve defined in paragraph 41.26(1)*"e."*

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

41.26(2) *Persons considered.*

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

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

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

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

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

41.26(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it will not exceed ½-acre in area. When outside a city plat, it will not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property will be determined in accordance with subrule 41.26(5).

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

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

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

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

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

41.26(6) *Availability.*

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

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

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

b. Reserved.

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

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

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

a. Payment resulting from damage to or destruction of an exempt resource will be considered a resource to the applicant/recipient the month following the month the payment was received. When the applicant/recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds will be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource will be considered a resource in the month following the month in which payment was received.

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

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

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

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

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

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

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

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

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

(3) The sponsored alien or the sponsor dies.

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

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

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

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

41.26(10) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment will not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and may include merchandise, grain held in storage, livestock raised for sale, and other unsold inventory. Supplies are items necessary for the operation of the enterprise, such as lumber, paint and seed. Capital assets are those assets that, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, any inventory or supplies retained by the household will not be considered a resource.

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

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

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

the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard for the eligible group.

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

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

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

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. through *e.* Reserved.

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

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

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

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

h. Support payments in cash will be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment for a member of the eligible group, made while the application is pending, will be treated as unearned income and deducted from the initial assistance grant(s). Any cash support payment for a member of the eligible group, except as described in paragraph 41.27(7) *"p,"* received by the recipient after the date of decision as defined in 441—subrule 40.24(4) will be refunded to child support services.

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

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

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

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

b. Reserved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The cost of any repairs needed.

(7) The cost of any travel required.

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

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

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

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

41.27(4) *Diversion of income.*

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

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

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

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

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

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement will be treated in the same manner as though the specified relative had attained majority.

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

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative will be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative will be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parent(s) will be treated in accordance with paragraph 41.27(8)*"c."*

(3) Reserved.

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

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

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

b. The value of the supplemental nutrition assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act, both as amended to December 31, 2024.

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

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

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968, both as amended to December 31, 2024.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, as amended to December 31, 2024, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act, as amended to December 31, 2024.

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

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936, as amended to December 31, 2024.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined in subrule 41.22(3), conditional to school attendance, will be exempt. However, any additional amount received for the person's dependents who are in the eligible group will be counted as nonexempt income.

s. Reserved.

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

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

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

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

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

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is a borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses

intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

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

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, kinship caregiver program, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988, as amended to December 31, 2024.

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

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

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

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

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

a. Reimbursements from a third party.

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

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

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

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

(2) Caring for a relative or fictive kin child or children placed in the home by a court order.

e. Reserved.

f. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

g. Federal or state earned income tax credit.

h. Supplementation from county funds providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the FIP, or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

i. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

j. A retroactive corrective payment.

k. The training allowance issued by the division of vocational rehabilitation, department of education.

l. Payments from the PROMISE JOBS program.

m. Reserved.

n. The training allowance issued by the department for the blind.

o. Payment(s) from a passenger(s) in a car pool.

p. Support refunded by child support services for the first month of termination of eligibility and the family does not receive the FIP.

q. and *r.* Reserved.

s. Income of a nonparental relative as defined in subrule 41.22(3) except when the relative is included in the eligible group.

t. and *u.* Reserved.

v. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

w. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

x. Reserved.

y. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined in paragraph 41.24(2)*"e."* The exemption applies through the entire month of the person's twentieth birthday.

Exception: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

z. Income attributed to an unmarried, underage parent in accordance with paragraph 41.27(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns age 18 on the first day of a month, the income of the self-supporting parent(s) becomes exempt as of the first day of that month.

aa. Reserved.

ab. Incentive payments received from participation in the adolescent pregnancy prevention programs.

ac. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

ad. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

ae. Interest and dividend income.

af. and *ag.* Reserved.

ah. Welfare reform and regular household honorarium income. All moneys paid to an FIP household in connection with the welfare reform demonstration longitudinal study or focus groups will be exempted.

ai. Diversion or self-sufficiency grants assistance as described in 441—Chapter 47.

aj. Payments from property sold under an installment contract as specified in paragraphs 41.26(4)*"b"* and 41.27(1)*"f."*

ak. All census earnings received by temporary workers from the Bureau of the Census.

41.27(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases.

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the earned income deduction described in paragraph 41.27(2)*"a,"* the work incentive disregard described in paragraph 41.27(2)*"c,"* and diversions described in subrule 41.27(4).

(2) The excluded parent will be permitted to retain that part of the parent's income to meet the parent's needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described in subrule 41.27(11).

(3) All remaining income of the excluded parent will be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but is living with the parent in the home of the eligible child(ren) will be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs 41.27(8)*"b"*(1) and 41.27(8)*"b"*(3) through *"b"*(10).

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, will receive a 20 percent earned income deduction.

(2) Reserved.

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, will be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent will also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described in subrule 41.27(11), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions in subparagraphs 41.27(8)*"b"*(1), *"b"*(3), and *"b"*(4) will be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs will be determined in accordance with the FIP standard of need for a family group of the same composition.

(6) The stepparent will be allowed the work incentive disregard described in paragraph 41.27(2)*"c"* from monthly earnings. The disregard will be applied to earnings that remain after all other deductions in subparagraphs 41.27(8)*"b"*(1) and 41.27(8)*"b"*(3) through *"b"*(5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described in subparagraphs 41.27(9)*"a"*(2) and *"a"*(3).

(7) The deductions described in subparagraphs 41.27(8)*"b"*(1) and 41.27(8)*"b"*(3) through *"b"*(6) will first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs 41.27(8)*"b"*(3) through *"b"*(5) will be subtracted from unearned income. Any remaining income will be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income will be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt nonrecurring lump sum received by a stepparent will be considered as income in the month received. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt will be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FIP, the income of the parent may be diverted to meet the unmet needs of the child(ren) of the current marriage except as described in subrule 41.27(11).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any child(ren) of the parent living in the home who is not eligible for FIP will be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, will be considered a separate unit.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parent(s), the income of each self-supporting parent will be considered available to the

eligible group after appropriate deductions. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 41.27(8)*"b"*(1) and 41.27(8)*"b"*(3) through *"b"*(7). Nonrecurring lump sum income received by the self-supporting parent(s) will be treated in accordance with subparagraph 41.27(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse will be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 41.27(8)*"b"*(1) and 41.27(8)*"b"*(3) through *"b"*(7). Nonrecurring lump sum income received by the spouse of the self-supporting parent will be treated in accordance with subparagraph 41.27(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person will be considered as one unit; the self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, will be considered a separate unit.

41.27(9) *Budgeting process.* Both initial and ongoing eligibility and benefits will be determined using a projection of income based on the best estimate of future income.

a. Initial eligibility.

(1) At time of application, all earned and unearned income received and anticipated to be received by the eligible group during the month the decision is made will be considered to determine eligibility for the FIP, except income that is exempt. All countable earned and unearned income received by the eligible group during the 30 days before the interview will be used to project future income. If the applicant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

When income is prorated in accordance with subparagraph 41.27(9)*"c"*(1) and paragraph 41.27(9)*"i,"* the prorated amount is counted as income received in the month of decision. Allowable work expenses during the month of decision will be deducted from earned income, except when determining eligibility under the 185 percent test defined in rule 441—41.27(239B). The determination of eligibility in the month of decision is a three-step process as described in rule 441—41.27(239B).

(2) When countable gross nonexempt earned and unearned income in the month of decision, or in any other month after assistance is approved, exceeds 185 percent of the standard of need for the eligible group, the application will be rejected or the assistance grant canceled. Countable gross income means nonexempt gross income, as defined in 441—41.27(239B), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income in the month of decision equals or is less than 185 percent of the standard of need for the eligible group, initial eligibility under the standard of need will then be determined. Initial eligibility under the standard of need is determined without application of the work incentive disregard as specified in paragraph 41.27(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the standard of need for the eligible group. When countable net earned and unearned income in the month of decision equals or exceeds the standard of need for the eligible group, the application will be denied.

(3) When the countable net income in the month of decision is less than the standard of need for the eligible group, the work incentive disregard described in paragraph 41.27(2)*"c"* will be applied when there is eligibility for this disregard. When countable net earned and unearned income in the month of decision, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the payment standard for the eligible group, the application will be denied.

When the countable net income in the month of decision is less than the payment standard for the eligible group, the eligible group meets income requirements. The amount of the FIP grant will be determined by subtracting countable net income in the month of decision from the payment standard for the eligible group, except as specified in subparagraph 41.27(9)*"a"*(4).

(4) Eligibility for the FIP for any month or partial month before the month of decision will be determined only when there is eligibility in the month of decision. The family composition for any month or partial month before the month of decision will be considered the same as on the date of decision. In determining eligibility and the amount of the assistance payment for any month or partial month preceding the month of decision, income and all circumstances except family composition in that month will be considered in the same manner as in the month of decision. When the applicant is eligible for some, but not all, months of the application period due to the time limit described in subrule 41.30(1), FIP eligibility will

be determined for the month of decision first, then the immediately preceding month, and so on until the time limit has been reached.

b. Ongoing eligibility.

(1) The department will prospectively compute eligibility and benefits when review information is submitted as described in 441—subrule 40.27(3). All countable earned and unearned income received by the eligible group during the previous 30 days will be used to project future income. If the participant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) When a change in eligibility factors occurs, the department will prospectively compute eligibility and benefits based on the change, effective no later than the month following the month the change occurred.

(3) Reserved.

(4) The earned income deduction for each wage earner as defined in paragraph 41.27(2)*"a"* and the work incentive disregard as defined in paragraph 41.27(2)*"c"* will be allowed.

c. Lump-sum income.

(1) Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, will be considered as income in the month received. Income received by an individual employed under a contract will be prorated over the period of the contract. Income received at periodic intervals or intermittently will be considered as income in the month received, except periodic or intermittent income from self-employment will be treated as described in paragraph 41.27(9)*"i."* When the income that is subject to proration is earned, appropriate disregards, deductions and diversions will be applied to the monthly prorated income. Income that is subject to proration is prorated when a lump sum is received before the month of decision and is anticipated to recur; or a lump sum is received during the month of decision or at any time during the receipt of assistance.

(2) Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 41.26(4) and 41.26(7) and paragraphs 41.27(8)*"b"* and *"c,"* will be treated in accordance with this rule. Nonrecurring lump-sum income will be considered as income in the month received and counted in computing eligibility and the amount of the grant unless the income is exempt. Nonrecurring lump-sum unearned income is defined as a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance or workers' compensation. When countable income, exclusive of the FIP grant but including countable lump-sum income, exceeds the needs of the eligible group, the case will be canceled or the application rejected. In addition, the eligible group will be ineligible for the number of full months derived by dividing the income by the standard of need for the eligible group. Any income remaining after this calculation will be applied as income to the first month following the period of ineligibility and disregarded as income thereafter. The period of ineligibility will begin with the month the lump sum is received.

1. When a nonrecurring lump sum is timely reported as required by 441—paragraph 40.27(4)*"f,"* recoupment will not be made for the month of receipt. When a nonrecurring lump sum is timely reported, but the timely notice as required by rule 441—16.2(17A) requires that the action be delayed until the second calendar month following the month of change, recoupment will not be made for the first calendar month following the month of change. When a nonrecurring lump sum is not timely reported, recoupment will be made beginning with the month of receipt.

2. The period of ineligibility will be shortened when the schedule of living costs as defined in subrule 41.28(2) increases.

3. The period of ineligibility will be shortened by the amount that is no longer available to the eligible group due to a loss or a theft or because the person controlling the lump sum no longer resides with the eligible group.

4. The period of ineligibility will also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82 and 85 at the time the expense is reported to the department; the cost of necessary

repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 41.26(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

5. When countable income, including the lump-sum income, is less than the needs of the eligible group, the lump sum will be counted as income for the month received. For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of ineligibility. During the period of ineligibility, individuals not in the eligible group when the lump-sum income was received may be eligible for the FIP as a separate eligible group. Income of this eligible group plus income, excluding the lump-sum income already considered, of the parent or other legally responsible person in the home will be considered as available in determining eligibility and the amount of the grant.

d. The third digit to the right of the decimal point in any computation of income and hours of employment will be dropped. This includes the calculation of the amount of a child support sanction as defined in paragraph 41.22(6)*"f."*

e. In any month for which an individual is determined eligible to be added to a currently active FIP case, the individual's needs will be included subject to the effective date of grant limitations as prescribed in rule 441—40.26(239B).

(1) When adding an individual to an existing eligible group, any income of that individual will be considered prospectively.

(2) The needs of an individual determined to be ineligible to remain a member of the eligible group will be removed prospectively effective the first of the following month.

f. Reserved.

g. When income received weekly or biweekly (once every two weeks) is projected for future months, it will be projected by adding all income received in the period being used and dividing the result by the number of instances of income received in that period. The result will be multiplied by four if the income is received weekly or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis will be budgeted in the same manner as the earnings of an employee. The countable income will be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income will be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment will be handled in accordance with subparagraphs 41.27(9)*"i"*(3) through *"i"*(5).

(1) When a self-employment enterprise that does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income will be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker will establish, with the cooperation of the client, a reasonable estimate that will be considered accurate and projected for three months, after which the income will be averaged and projected for the same period of time. Any changes in self-employment will be considered in accordance with subparagraphs 41.27(9)*"i"*(3) through *"i"*(5).

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, and after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department will recompute the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses will be computed on the basis of the change.

j. Special needs.

(1) A special need as defined in subrule 41.28(3) must be documented before payment will be made.

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system.

(3) An ongoing special need is considered in determining need for the calendar month following the calendar month in which the special need is entered on the automated benefit calculation system.

(4) When the special need continues, payment will be included, prospectively, in each month's FIP grant. When the special need ends, payment will be removed prospectively. Any overpayment for a special need will be recouped.

k. When a family's assistance for a month is subject to recoupment because the family was not eligible, individuals applying for assistance during the same month may be eligible for the FIP as a separate eligible group. Income of this new eligible group plus income of the parent or other legally responsible person in the home will be considered as available in determining eligibility and the amount of the grant. The income of an ineligible parent or other legally responsible person will be considered prospectively in accordance with subrules 41.27(4) and 41.27(8).

41.27(10) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) (as amended to December 31, 2024) on behalf of the alien, the income of the alien will be deemed to include the income of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the income of the sponsor and the sponsor's spouse deemed to the alien will be the total gross earned and unearned income remaining after allowing the earned income deduction described in paragraph 41.27(2)*"a,"* the work incentive disregard described in paragraph 41.27(2)*"c,"* and diversions described in subrule 41.27(4). The following are exceptions to deeming of a sponsor's income:

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

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

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

(3) The sponsored alien or the sponsor dies.

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

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

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

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

41.27(11) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 41.24(8) or 41.25(5), or who has been disqualified under subrule 41.25(10) or rule 441—46.29(239B), or who is required to be included in the eligible group according to paragraph 41.28(1)*"a"* and has failed to cooperate. This restriction applies to paragraph 41.27(4)*"a"* and subrule 41.27(8).

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

441—41.28(239B) Need standards.

41.28(1) *Definition of the eligible group.* The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive supplemental security income under Title XVI of the Social Security Act, as amended to December 31, 2024. There will be at least one child in the eligible group except when the only eligible child is receiving supplemental security income. The unborn child is not considered a member of the eligible group for purposes of establishing the number of people in the eligible group.

a. The following persons will be included (except as otherwise provided in these rules), without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as payee when the parent is in the home, but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the incapacitated stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be obtained from either an independent physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on a form prescribed by the department. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on a form prescribed by the department. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity.

41.28(2) *Schedule of needs.* The schedule of living costs represents 100 percent of basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the "standard of need" as defined in rule 441—40.21(239B). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—41.27(239B). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in and are eligible for an FIP grant. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the assistance grant, when these needs must be determined in accordance with the "payment standard" as defined in rule 441—40.21(239B). The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below.

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
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
Communi-cations	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transpor-tation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Includes bus fares and other out-of-pocket costs of operating a privately owned vehicle.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home will be considered a separate eligible group when the relative is receiving the FIP assistance for the relative's own children.

(2) When the unmarried specified relative under age 19 is living in the same home with a parent or parents who receive the FIP, the needs of the specified relative, when eligible, will be included in the same eligible group with the parent(s). When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker will be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker will be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent(s) who receives the FIP but the specified relative is not an eligible child, need of the specified relative will be determined in the same manner as though the specified relative had attained majority. When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need will be determined in the same manner as though the specified relative had attained majority. When the unmarried specified relative is under the age of 18 and living in the same home with a parent(s) who does not receive the FIP, the needs of the specified relative, when eligible, will be included in the assistance grant with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined in subrule 41.22(3), only the needs of the eligible children will be included in the assistance grant. When the unmarried specified relative is aged 18, need will be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group is receiving supplemental security income benefits, the person, income, and resources will not be considered in determining FIP benefits for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of assistance, the assistance grant will be computed on the basis of their comprising one eligible group. This rule is not intended to mandate that an application for assistance be made for children who are not the natural or adoptive children of the applicant.

41.28(3) *Special needs.* On the basis of demonstrated need the following special needs will be allowed, in addition to the basic needs.

a. School expenses. Any specific charge, excluding tuition, for a child's education made by the school, or in accordance with school requirements in connection with a course in the curriculum, will be allowed provided the allowance will not exceed the reasonable cost required to meet the specifications of the course, and the student is actually participating in the course at the time the expense is claimed. Payment will not be made for ordinary expenses for school supplies.

b. Guardian/conservator fee. An amount not to exceed $10 per case per month may be allowed for guardian's/conservator's fees when authorized by appropriate court order. No additional payment is permitted for court costs or attorney's fees.

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

441—41.29(239B) Composite FIP/SSI cases. When persons in the FIP household, who would ordinarily be in the eligible group, are receiving supplemental security income benefits, the following subrules will apply:

41.29(1) *Pending SSI approval.* When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the FIP grant pending approval of supplemental security income.

41.29(2) *Ownership of property.* When property is owned by both the supplemental security income beneficiary and the FIP recipient, each will be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

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

441—41.30(239B) Time limits.

41.30(1) *Sixty-month limit.* Assistance will not be provided to an FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under FIP or under any program in another state that is funded by the federal Temporary Assistance for Needy Families (TANF) block grant unless the applicant or recipient family is eligible for a hardship as defined in subrule 41.30(3). The 60-month period need not be consecutive. In two-parent households or households that include a parent and a stepparent, the 60-month limit is determined when either a parent or stepparent has received assistance for 60 months.

a. An "adult" is any person who is a parent of the FIP child in the home, the parent's spouse, or included as an optional member under subparagraph 41.28(1)*"b"*(1) or *"b"*(2).

b. "Assistance," for the purpose of this rule, will include any month for which the adult receives an FIP grant or a payment in another state using federal TANF funds that the other state deems countable toward the 60-month federal limit. Assistance received for a partial month will count as a full month.

41.30(2) *Determining number of months.*

a. In determining the number of months an adult received assistance, the department will consider toward the 60-month limit:

(1) Assistance received even when the parent is excluded from the grant unless the parent, or both parents in a two-parent household, are SSI recipients.

(2) Assistance received by an optional member of the eligible group as described in subparagraphs 41.28(1)*"b"*(1) and *"b"*(2). However, once the person has received assistance for 60 months, the person is ineligible but assistance may continue for other persons in the eligible group. The entire family is ineligible for assistance when the optional member who has received assistance for 60 months is the incapacitated stepparent on the grant as described in subparagraph 41.28(1)*"b"*(3).

b. When the parent, or both parents in a two-parent household, have received 60 months of FIP assistance and are subsequently approved for supplemental security income, FIP assistance for the children may be granted, if all other eligibility requirements are met.

c. When a minor parent and child receive FIP on the adult parent's case and the adult parent is no longer eligible due to the 60-month limit on FIP assistance, the minor parent may reapply for FIP as a minor parent living with a self-supporting parent.

d. In determining the number of months an adult received assistance, the department will not consider toward the 60-month limit any month for which FIP assistance was not issued for the family, such as:

(1) A month of suspension.

(2) A month for which no grant is issued due to the limitations described in rules 441—45.26(239B) and 441—45.27(239B).

e. The department will not consider toward the 60-month limit months of assistance a parent or pregnant person received as a minor child and not as the head of a household or married to the head of a household. This includes assistance received for a minor parent for any month in which the minor parent was a child on the adult parent's or the specified relative's FIP case.

f. The department will not consider toward the 60-month limit months of assistance received by an adult while living in Indian country (as defined in 18 U.S.C. Section 1151 as amended to December 31, 2024) or a Native Alaskan village where at least 50 percent of the adults were not employed.

41.30(3) *Exception to the 60-month limit.* A family may receive FIP assistance for more than 60 months as defined in subrule 41.30(1) if the family qualifies for a hardship exemption as described in this subrule. "Hardship" is defined as a circumstance that is preventing the family from being self-supporting. However, the family's safety will take precedence over the goal of self-sufficiency.

a. Reserved.

b. Eligibility determination. Eligibility for the hardship exemption will be determined on an individual family basis. A hardship exemption will not begin until the adult in the family has received at least 60 months of FIP assistance.

c. Hardship exemption criteria. Circumstances that may lead to a hardship exemption may include the following:

(1) Domestic violence. "Domestic violence" means that the family includes someone who has been battered or subjected to extreme cruelty. It includes:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual.
2. Sexual abuse.
3. Sexual activity involving a dependent child.
4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities.
5. Threats of, or attempts at, physical or sexual abuse.
6. Mental abuse.
7. Neglect or deprivation of medical care.

(2) Lack of employability.

(3) Lack of suitable child care as defined in 441—subrule 93.4(5).

(4) Chronic or recurring medical conditions or mental health issues, or an accident or disease, when verified by a professional. The applicant or recipient will follow a treatment plan to address the condition or issue.

(5) Housing situations that make it difficult or impossible to work.

(6) Substance use disorder. A family requesting a hardship exemption due to substance use disorder will be required to obtain clinical assessment and follow an intensive treatment plan.

(7) Having a child whose circumstances require the parent to be in the home. This may include but is not limited to a child as defined in rule 441—170.1(237A) or a child receiving child welfare, juvenile court or juvenile justice services. The safety of the child will take precedence over the goal of self-sufficiency.

(8) Reserved.

(9) Other circumstances that prevent the family from being self-supporting.

d. Eligibility for a hardship exemption.

(1) Families may be eligible for a hardship exemption when circumstances prevent the family from being self-supporting. The hardship condition shall be a result of a past or current experience that is affecting the family's current functioning. Current experience may include fear of an event that is likely to occur in the future. The definition of the hardship barrier relies upon the impact of the circumstances upon the family's ability to leave FIP rather than the type of circumstances.

(2) Families with FIA-responsible persons who are not exempt from referral as defined in subrule 41.24(2) determined eligible for more than 60 months of FIP shall make incremental steps toward overcoming the hardship and participate to their maximum potential in activities reasonably expected to result in self-sufficiency.

(3) Barriers to economic self-sufficiency that an FIA-responsible person who is not exempt as defined in subrule 41.24(2) has that were known and existing before the family reached the 60-month limit will not be considered as meeting eligibility criteria for hardship unless the individual complied with PROMISE JOBS activities offered to overcome that specific barrier.

e. Requesting a hardship exemption.

(1) Families that have or are close to having received 60 months of assistance as defined in subrule 41.30(1) may request a hardship exemption. Requests for the hardship exemption shall be made on a hardship request form prescribed by the department. In addition, families that have received assistance for 60 months and are no longer receiving FIP shall complete an application form prescribed by the department as a condition for regaining FIP eligibility. Failure to provide the required application within ten days from the date of the department's request will result in denial of the hardship request.

(2) In families that request FIP beyond 60 months, all adults as defined in subrule 41.30(1) shall sign the request. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the request.

(3) Requests for a hardship exemption will not be accepted prior to the first day of the family's fifty-ninth month of assistance. The date of the request will be the date an identifiable hardship request form prescribed by the department is received in any department or PROMISE JOBS office. An identifiable form is one that contains a legible name and address and that has been signed.

(4) To receive more than 60 months of FIP assistance, families must be eligible for a hardship exemption and meet all other FIP eligibility requirements.

(5) When an adult as defined in subrule 41.30(1) who has received assistance for 60 months joins a recipient family that has not received 60 months of assistance, eligibility will continue only if the recipient family submits a hardship request form prescribed by the department and is approved for a hardship exemption as described in subrule 41.30(3) and meets all other FIP eligibility requirements.

(6) When an adult as defined in subrule 41.30(1) joins a recipient family that is in an exemption period, the current exemption period will continue, if the recipient family continues to meet all other eligibility requirements, regardless of whether the joining adult has received FIP for 60 months.

(7) When two parents who are in a hardship exemption period separate, the remainder of the exemption period, if there is a need, will follow the parent who retains the current FIP case.

f. Determination of hardship exemption.

(1) A determination on the request will be made as soon as possible, but no later than 30 days following the date an identifiable hardship request form prescribed by the department is received in any department or PROMISE JOBS office. A written notice of decision will be issued to the family the next working day following a determination of eligibility or ineligibility for a hardship exemption. The 30-day time standard will apply except in unusual circumstances, such as when the department and the family have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

(2) When a Financial Support Application is required to regain FIP eligibility, the 30-day time frame in rule 441—40.25(239B) will apply.

(3) Income maintenance will determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The department will advise the applicant or recipient about how to obtain necessary documents. Upon request, the department will provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.

2. Statements from professionals or other individuals with knowledge of the hardship barrier.

3. Statements from vocational rehabilitation or other job training professionals.

4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.

5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter will not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

6. Actively pursuing verification of a disability through the Social Security Administration may not be sufficient to grant hardship status, but may be used to support other evidence.

(6) The department will notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family will be allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.24(1) or 441—paragraph 40.27(4)*"c."* Failure to supply the required information or verification, or refusal by the family to authorize the department to secure the information or verification from other sources, will result in denial of the family's request for a hardship exemption.

(7) and (8) Reserved.

(9) Recipients whose FIP assistance is canceled at the end of the sixtieth month will be eligible for reinstatement as described in 441—subrule 40.22(5) when a hardship request form prescribed by the department is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(10) When a hardship request form prescribed by the department is not received before the effective date of the FIP cancellation and a Financial Support Application is required for the family to regain FIP eligibility, the effective date of assistance will be no earlier than seven days from the date of application as described in rule 441—40.26(239B).

(11) Eligibility for a hardship exemption will last for six consecutive calendar months. Exception: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Financial Support Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends on receiving a hardship exemption, the family shall submit a new hardship request form prescribed by the department. A new hardship exemption determination will be required prior to FIP approval.

(12) FIP received for a partial month of the six-month hardship exemption period will count as a full month.

(13) There is no limit on the number of hardship exemptions a family may receive over time.

g. Six-month FIA. Families who request a hardship exemption shall develop and sign a six-month FIA as defined in 441—93.4(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.30(1) shall sign the six-month FIA unless the adult is a stepparent and is not requesting assistance or is exempt as specified at subrule 41.24(2).

(1) The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption will require a new six-month FIA. Failure to develop or sign a six-month FIA will result in denial of the family's hardship exemption request.

(2) Families that request a hardship exemption will be notified verbally and will be hand-issued the notice of a scheduled appointment for orientation and FIA development. If the notice of appointment cannot be hand-issued, at least five working days will be allowed from the date the notice is mailed for a participant to appear for the scheduled appointment for orientation and FIA development unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(3) Failure to attend a scheduled interview when required, except for reasons beyond the adult's control, will result in a denial of the family's hardship exemption request. In two-parent families, both parents will be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may participate in the interview.

(4) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family to monitor progress. These contacts need not be in person. Time and attendance reports shall be required as specified in 441—subrule 93.10(2).

(5) The six-month FIA shall be renegotiated and amended under the circumstances described in 441—subrule 93.4(8).

(6) Any family that is not exempt from referral as defined in subrule 41.24(2), that has been granted a hardship exemption, and that does not follow the terms of the family's six-month FIA will have chosen an LBP in accordance with 441—Chapter 41 and 441—Chapter 93.

h. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 2506.

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UNEMPLOYED PARENT
[Prior to 7/1/83, Social Services[770] Ch 42]
[Prior to 2/11/87, Human Services[498]]
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CHAPTER 43
ALTERNATE PAYEES
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[Prior to 2/11/87, Human Services[498]]
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CHAPTER 44
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CHAPTER 45
PAYMENT

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

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441—45.1 to **45.20** Reserved.

441—45.21(239B) Issuing payment. The department may issue assistance payments pursuant to Iowa Code section 239B.3(3).

45.21(1) *Electronic access card.* The department will make payments available through an electronic access card issued to the payee except when:

a. The recipient requests direct deposit; or

b. The department determines it is not practicable to issue the payment by electronic access card.

45.21(2) *Direct deposit.* The department will issue payments by direct deposit to the recipient's own account in a financial institution if the recipient completes a form prescribed by the department to request direct deposit.

45.21(3) *Warrant.* The department will issue payments by warrant when the recipient has not requested direct deposit and the department determines it is not practicable to issue payment by electronic access card. These circumstances include but are not limited to the following:

a. A one-time payment is issued.

b. The payee is a representative payee, conservator, or guardian who is not part of the family investment program (FIP) assistance unit.

c. The payee is unable to provide a social security number or an individual taxpayer identification number.

[**ARC 9259C**, IAB 5/14/25, effective 7/1/25]

441—45.22(239B) Return. Assistance warrants cannot be forwarded. When warrants cannot be delivered by the post office, they shall be returned to the department.

[**ARC 9259C**, IAB 5/14/25, effective 7/1/25]

441—45.23(239B) Held warrants. A warrant may be held by the department only in the following instances:

45.23(1) The recipient's whereabouts is unknown.

45.23(2) The recipient is not in the home due to an emergency and it is not known who will be serving as emergency payee.

[**ARC 9259C**, IAB 5/14/25, effective 7/1/25]

441—45.24(239B) Underpayment. A corrective payment will be made when the recipient receives a payment in an amount less than that for which the recipient was eligible due to an administrative or client error or the recipient reports the completion of the federal tax return requiring repayment to Internal Revenue Service of excess advance earned income credit payments received in the prior calendar year.

45.24(1) Attribution of underpayments.

a. An underpayment may be attributed to the department as a result of one of the following circumstances:

(1) Misfiling or loss of forms or documents.

(2) Errors in typing or copying.

(3) Computer input errors.

(4) Mathematical errors.

(5) Failure to certify assistance in the correct amount when all essential information was available to the department.

(6) Failure to make prompt revisions in grants following changes in policies requiring the changes as of a specific date.

b. An underpayment may be attributed to the client as a result of one of the following circumstances:

(1) Information reported in error, oral or written, regarding the client's income, resources, or other circumstances that may affect eligibility or the amount of assistance received.

(2) Failure to timely report changes in income, resources, or other circumstances that may affect eligibility or the amount of assistance received.

45.24(2) Conditions under which a retroactive corrective payment may be made.

a. Retroactive corrective payments will be made for all underpayments.

b. Any retroactive corrective payment for which the recipient is eligible will first be applied to any unpaid overpayment before the balance, if any, is paid to the recipient.

c. Retroactive corrective payments will be made for underpayments discovered on and after October 1, 1981, regardless of when the underpayment occurred. Recipients and former applicants and recipients are responsible for supplying any information needed to determine the amount of an underpayment.

45.24(3) The amount of the corrective payment to the recipient for repayment to Internal Revenue Service of excess advance earned income credit payments will be computed on the basis of the earnings considered in determining the family investment program grant for the prior year.

45.24(4) A retroactive corrective payment is:

a. Exempt from consideration as income.

b. Exempt from consideration as a resource in the month received and the following month.

[**ARC 9259C**, IAB 5/14/25, effective 7/1/25]

441—45.25(239B) Deceased payees. A retroactive corrective payment will be made for deceased payees only when the payment was approved by the department before the recipient's death. Payment for a special need will be made only when the payment is entered on the automated benefit calculation system before the effective date of cancellation.

[**ARC 9259C**, IAB 5/14/25, effective 7/1/25]

441—45.26(239B) Limitation on payment. A payment will be made to an eligible recipient only when the amount of the assistance is $10 or more.

[**ARC 9259C**, IAB 5/14/25, effective 7/1/25]

441—45.27(239B) Rounding of need standard and payment amount. The need standard and monthly payment amount will be rounded down to the next whole dollar when the result of determining the standard of need or the payment amount is not a whole dollar.

[**ARC 9259C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, and 239B.7.

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CHAPTER 46
OVERPAYMENT RECOVERY

[Prior to 7/1/83, Social Services[770] Ch 46]
[Prior to 2/11/87, Human Services[498]]
[Rescinded IAB 2/12/97, effective 3/1/97]

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

441—46.1 to **46.20** Reserved.

441—46.21(239B) Definitions.

"Agency error" in overpayments means:

1. The same circumstances as described in 441—subrule 45.24(1) pertaining to underpayments, or
2. Any error that is not a client or procedural error.

"Client" means a current or former applicant or recipient of the family investment program.

"Client error" means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances that may affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances as required by rule 441—40.27(239B);
3. Failure to refund to child support services any nonexempt payment from the absent parent received after the date the decision on eligibility was made; or
4. Access of benefits issued via the electronic access card at a prohibited location pursuant to 441—subrule 41.25(11).

"Overpayment" means any assistance payment received in an amount greater than the amount the eligible group is entitled to receive or the amount of any payment accessed and any associated fees for accessing the benefits at a prohibited location pursuant to 441—subrule 41.25(11).

"Procedural error" means a technical error that does not in and of itself result in an overpayment. Procedural errors include:

1. Failure to secure a properly signed application at the time of initial application or reapplication.
2. Failure to secure a properly signed form prescribed by the department to request FIP beyond 60 months as described in 441—subrule 41.30(3).
3. Failure of the department to conduct the interviews described in 441—subrules 40.24(2) and 40.27(1).
4. Failure to request a review form prescribed by the department at the time of a semiannual or annual review.
5. Failure of department staff to cancel the family investment program benefits when the client submits a review form prescribed by the department that is not complete as defined in 441—paragraph 40.27(4)*"b."* However, overpayments of grants as defined above based on incomplete reports are subject to recoupment.

"Recoup" means reimburse, return, or repay an overpayment.

"Recoupment" means the repayment of an overpayment, either by a payment from the client or an amount withheld from the assistance grant or both.

[**ARC 9260C**, IAB 5/14/25, effective 7/1/25]

441—46.22(239B) Monetary standards.

46.22(1) *Amount subject to recoupment.* All family investment program overpayments will be subject to recoupment.

46.22(2) *Grant issued.* When recoupment is made by withholding from the family investment program grant, the grant issued will be for no less than $10.

[**ARC 9260C**, IAB 5/14/25, effective 7/1/25]

441—46.23(239B) Notification and appeals. All clients will be notified by the department of inspections, appeals, and licensing, as described in 441—subrule 11.2(2), when it is determined that an overpayment exists. Notification will include the amount, date and reason for the overpayment. The department will provide additional information regarding the computation of the overpayment upon the client's request. The client may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—Chapter 2506.

[**ARC 9260C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—46.24(239B) Determination of overpayments. All overpayments due to agency or client error or due to assistance paid pending an appeal decision will be recouped. A procedural error alone does not result in an overpayment.

46.24(1) *Agency error.* When an overpayment is due to an agency error, recoupment will be made, including those instances when errors by the department prevent the requirements in 441—subrule 41.22(6) or 41.22(7) from being met or when the client receives a duplicate grant.

a. An overpayment of any amount is subject to recoupment with one exception: when the client receives a grant that exceeds the amount on the most recent notice from the department, recoupment will be made only when the amount received exceeds the amount on the notice by $10 or more.

b. An overpayment due to agency error will be computed as if the information had been acted upon timely.

46.24(2) *Assistance paid pending appeal decision.* Recoupment of overpayments resulting from assistance paid pending a decision on an appeal hearing will begin no later than the month after the month in which the final decision is issued.

46.24(3) *Client error.*

a. An overpayment due to client error will be computed as if the information had been reported and acted upon timely.

b. Overpayments due to failure to refund payments received from the absent parent will be the total nonexempt support payment made for members of the eligible group at the time the support payment was received. In addition, assistance payments made to meet the needs of the eligible group may also be subject to recoupment under provisions in 441—subrule 41.22(6).

c. An overpayment due to a recipient's accessing benefits via the electronic access card at a prohibited location will be the total of the transactions and any associated fees for accessing the benefits at the prohibited location pursuant to 441—subrule 41.25(11).

46.24(4) *Failure to cooperate.* Failure to cooperate in the investigation of alleged overpayments will result in ineligibility for the months in question and the overpayment will be the total amount of assistance received during those months.

[**ARC 9260C**, IAB 5/14/25, effective 7/1/25]

441—46.25(239B) Source of recoupment. Recoupment will be made from basic needs. The minimum recoupment amount will be the amount prescribed in subrule 46.25(3). Regardless of the source, the client may choose to make a lump sum payment, make periodic installment payments when an agreement to do this is made with the department of inspections, appeals, and licensing, or have repayment withheld from the grant. The client shall sign a form prescribed by the department when requested to do so by the department of inspections, appeals, and licensing. When the client fails to make the agreed upon payment, the agency will reduce the grant.

46.25(1) and **46.25(2)** Reserved.

46.25(3) *Basic needs.*

a. Recoupment by withholding from basic needs for overpayments due to client error or a combination of client and agency errors will be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

b. Recoupment by withholding from basic needs for overpayments due to the continuation of benefits pending a decision on an appeal as provided under 441—Chapter 2506 or a combination of continued benefits and agency or client errors will be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

c. Recoupment by withholding from basic needs for overpayments due to agency error will be 1 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).
[**ARC 9260C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—46.26 Reserved.

441—46.27(239B) Procedures for recoupment.

46.27(1) Reserved.

46.27(2) *Referral.* When the department determines that an overpayment exists, the case will be referred to the department of inspections, appeals, and licensing for investigation, recoupment, or referral for possible prosecution.

46.27(3) Reserved.

46.27(4) *Change of circumstances.* When financial circumstances change, any agreement to pay a debt is subject to revision.

46.27(5) *Collection.* Recoupment for overpayments will be made from the parent or nonparental relative who was the caretaker relative, as defined in 441—subrule 41.22(3), at the time the overpayment occurred. When both parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

46.27(6) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the case is canceled and the amount of the overpayment is less than $35. If the case is reopened within three years, recoupment is initiated again. Recoupment will be waived on nonfraud overpayments of less than $35 that have been held in suspense for three years.
[**ARC 9260C**, IAB 5/14/25, effective 7/1/25]

441—46.28 Reserved.

441—46.29(239B) Fraudulent misrepresentation of residence. A person convicted in a state or federal court, or in an administrative hearing, of having made a fraudulent statement or representation of the person's place of residence in order to receive assistance simultaneously from two or more states will be ineligible for assistance for ten years. For the purpose of this rule, the term "assistance" means assistance under Titles IV-A or XIX of the Social Security Act, as amended to December 31, 2024, or the Food Stamp Act of 1977, as amended to December 31, 2024, or benefits in two or more states under the Supplemental Security Income program under Title XVI. The ten-year period begins on the date the person is convicted. The prohibition does not apply to a convicted person who is pardoned by the President of the United States, beginning with the month after the pardon is given.
[**ARC 9260C**, IAB 5/14/25, effective 7/1/25]

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CHAPTER 47
DIVERSION INITIATIVES

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

441—47.1 to **47.20** Reserved.

441—47.21(239B) Definitions.

"Appropriate responsible administrator" means the administrator of the department of workforce development's division of workforce development center administration, or the administrator's designee.

"Candidate" means anyone expressing an interest in the family self-sufficiency grants program.

"Family" means "assistance unit" as defined in rule 441—40.21(239B).

"Family investment program" or *"FIP"* means the cash grant program provided by 441—Chapters 40 and 41, designed to sustain Iowa families.

"Family self-sufficiency grants" or *"FSSG"* means the payments made to specific PROMISE JOBS participants, to vendors on behalf of specific PROMISE JOBS participants, or for services to specific PROMISE JOBS participants.

"Immediate, short-term assistance" means that assistance provided under this chapter will be authorized upon determination of need and that it will not occur on a regular basis.

"Iowa workforce development" or *"IWD"* means the agency that develops and administers employment, placement and training services in Iowa and is contracted by the department to administer PROMISE JOBS services statewide.

"IWD service delivery area" means the Iowa workforce development service delivery areas designated to provide PROMISE JOBS services.

"Local plan for family self-sufficiency grants" means the written policies and procedures for administering the grants for families as set forth in the plan developed by the PROMISE JOBS IWD service delivery area as described in rule 441—47.26(239B).

"Participant" means anyone receiving assistance under this chapter.

"PROMISE JOBS contract" means the agreement between the department and Iowa workforce development regarding delivery of PROMISE JOBS services.

"PROMISE JOBS participant" means any person receiving services through PROMISE JOBS. A PROMISE JOBS participant must be a member of an eligible FIP household.

"Promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program" means the department's work and training program as described in 441—Chapter 93.

[**ARC 9261C**, IAB 5/14/25, effective 7/1/25]

441—47.22(239B) Availability of the family self-sufficiency grants program. The family self-sufficiency grants program will be available statewide.

47.22(1) The program will be available for use by the IWD service delivery areas. Under the PROMISE JOBS contract, IWD shall allocate the funds available for authorization to each of the service delivery areas based on the allocation standards used for PROMISE JOBS service delivery purposes.

47.22(2) The department retains the funds that are released through the PROMISE JOBS expense allowance authorization system.

[**ARC 9261C**, IAB 5/14/25, effective 7/1/25]

441—47.23(239B) General criteria. Family self-sufficiency grants candidates shall be PROMISE JOBS participants. Participation in the family self-sufficiency grants program is voluntary and will be based on an informed decision by the family. Further, candidates must have identifiable barriers to obtaining or retaining employment that can be substantially addressed through the assistance offered by family self-sufficiency grants.

[**ARC 9261C**, IAB 5/14/25, effective 7/1/25]

441—47.24(239B) Assistance available in family self-sufficiency grants. Family self-sufficiency grants will be authorized for removing an identified barrier to self-sufficiency when it can be reasonably anticipated that the assistance will enable PROMISE JOBS participant families to obtain or retain employment in the two full calendar months following the date of authorization of payment. For example, if a payment is authorized on August 20, it should be anticipated that the participant can find employment in September or October.

47.24(1) *Employment does not occur.* If employment does not occur in the anticipated two-calendar-month period or if the participant loses employment in spite of the self-sufficiency grant, no penalty is incurred and no overpayment has occurred.

47.24(2) *Types of assistance.* The department, in conjunction with IWD, will determine those barriers to self-sufficiency that can be considered for family self-sufficiency grants such as but not limited to auto maintenance or repair, licensing fees, child care, and referral to other resources, including those necessary to address questions of domestic violence. The IWD service delivery areas will have the opportunity to adjust the list of approvable barriers to self-sufficiency based on local resources and circumstances. These adjustments will be approved by the department and the appropriate responsible administrator prior to implementation.

47.24(3) *Limit on assistance.* The total payment limit per FIA-responsible person is $1,000 per year. A year for a family will be the 12 fiscal months following the date of authorization of the initial payment for the family. A fiscal month begins and ends in different calendar months.

47.24(4) *Frequency of assistance.* Family self-sufficiency grants are intended to provide immediate and short-term assistance and must meet the criteria in this rule. While a family may be a candidate more than once and may receive payments in consecutive months in some circumstances, payments will not be established as regular or ongoing.

47.24(5) *Supplanting.* Family self-sufficiency grants will not be used for services already available through the department, PROMISE JOBS, or other local resources at no cost.

47.24(6) *Relationship to the family investment agreement.* Family self-sufficiency grants are separate from the PROMISE JOBS family investment agreement process. While the family investment agreement must be honored at all times and renegotiated and amended if family circumstances require it, no family will be considered to be choosing the limited benefit plan if the family chooses not to participate in the family self-sufficiency grant program.

47.24(7) *Issuing payments.* Family self-sufficiency grants are PROMISE JOBS benefits and will be authorized through the PROMISE JOBS expense allowance system. Payments may be issued to the participants or to a vendor for support services provided to the family. The department in conjunction with the appropriate responsible administrator will have discretion in determining method of payment. The IWD service delivery area will have the opportunity to adjust these payment options in an individual case based on circumstances and needs of the family with the approval of the department and the appropriate responsible administrator prior to implementation.

[**ARC 9261C**, IAB 5/14/25, effective 7/1/25]

441—47.25(239B) Application, notification, and appeals.

47.25(1) *Application elements.* Each IWD service delivery area shall use the established application form to be completed by the PROMISE JOBS participant and the PROMISE JOBS worker when the participant asks to be a candidate for a family self-sufficiency grant. The application form must contain the following elements:

a. An explanation of family self-sufficiency grants and the expectations of the program.

b. Identification of the family and the person representing the family.

c. A clear description of the barrier to self-sufficiency to be considered.

d. Demonstration of how removing the barrier is related to obtaining or retaining employment, meeting the criteria in rule 441—47.24(239B).

e. Demonstration of why the department, PROMISE JOBS, or community resources cannot deal with the barrier to self-sufficiency.

f. Anticipated cost of removing the barrier to self-sufficiency.

47.25(2) *Notification process.* PROMISE JOBS shall use a form prescribed by the department to notify the candidate of the PROMISE JOBS decision regarding the family self-sufficiency grant. Decisions shall be in accordance with policies of this chapter and the local plan.

a. On approval, the form shall indicate the amount of the benefit that will be issued to the candidate or paid to a vendor, or the service that will be provided to the family.

b. On denial, the form shall indicate the reason for denial.

47.25(3) *Appealable actions.* The PROMISE JOBS decisions on family self-sufficiency grants may be appealed pursuant to 441—Chapter 2506. Copies of the local plan as described in rule 441—47.26(239B) shall be included with the appeal summary.

47.25(4) *Nonappealable actions.* PROMISE JOBS participants will not be entitled to an appeal hearing if the sole basis for denying, terminating or limiting assistance from family self-sufficiency grants is that self-sufficiency grant funds have been reduced, exhausted, eliminated, or otherwise encumbered.

[**ARC 9261C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—47.26(239B) Approved local plans for family self-sufficiency grants. Each IWD service delivery area shall create and provide to the department the written policies and procedures for administering family self-sufficiency grants. The plan will be reviewed for required elements and quality of service to ensure that it meets the purpose of the program and approved by the department and the appropriate responsible administrator. The written policies and procedures shall be available to the public at county offices and PROMISE JOBS offices. At a minimum, these policies and procedures shall contain or address the following:

47.26(1) *A plan overview.* The plan overview shall contain a general description detailing:

a. Any types of services or assistance that will be excluded from consideration for family self-sufficiency grants by the IWD service delivery area.

b. How determinations will be made that the service or assistance requested meets the program's objective of helping the family obtain or retain employment.

c. How determinations will be made that the proposed family self-sufficiency grant is not supplanting as required in subrule 47.24(5).

d. Services established and any maximum (and minimum, if any) values of payments of the services established by the IWD service delivery area.

e. Verification procedures or standards for documenting barriers, using written notification policies found in rule 441—93.10(239B).

f. Verification procedures or standards for documenting employment attempts if not already tracked by PROMISE JOBS procedures, using policies found in rule 441—93.10(239B).

g. How applications will be processed timely to address barriers to obtaining or retaining employment.

h. Follow-up procedures on participant effort.

i. Procedures for tracking of family self-sufficiency grant authorizations in order to stay within the amount allocated.

j. How staff will be trained to administer the program.

47.26(2) *Intake and eligibility determination.* The policies and procedures shall describe:

a. How families most likely to benefit from self-sufficiency grant assistance are identified.

b. How families can apply for self-sufficiency grant assistance.

c. How families will be informed of the availability of self-sufficiency grant assistance, its voluntary nature, and how the program works.

[**ARC 9261C**, IAB 5/14/25, effective 7/1/25]

441—47.27(239B) Evaluation of family self-sufficiency grants. The department, in conjunction with IWD, will develop an evaluation plan. The evaluation plan will:

1. Describe tracking procedures.
2. Describe the plan for evaluation.
3. Describe how measurable results will be determined.
4. Identify any support needed to conduct an evaluation.

[**ARC 9261C**, IAB 5/14/25, effective 7/1/25]

441—47.28(239B) Recovery of FSSG overpayments. An overpayment exists when an item(s) for which the funds were awarded was not purchased, a duplicate payment was issued or when, according to receipts, the item(s) purchased costs less than the funds received. For purposes of overpayment and recovery, an FSSG payment is considered a PROMISE JOBS expense payment and is subject to rule 441—93.12(239B), recovery of PROMISE JOBS expense payments.

[**ARC 9261C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code sections 234.6 and 239B.11.

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

CHAPTER 48
PROMOTING AWARENESS OF THE BENEFITS OF A HEALTHY MARRIAGE

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

441—48.1(234) Definitions.

"Asset" means the same as defined in Iowa Code section 239.1 to the extent it is consistent with 7 CFR 273.8 as amended to March 1, 2025.

"SNAP" means the supplemental nutrition assistance program under 441—Chapter 65.

[**ARC 9065C**, IAB 4/2/25, effective 6/1/25]

441—48.2(234) Eligibility criteria. Eligibility for the promoting awareness of the benefits of a healthy marriage program is always determined in conjunction with determination of eligibility for SNAP.

48.2(1) *Application.* There is no separate application for the program. Eligibility for the program is determined whenever the department determines a household's eligibility for SNAP.

48.2(2) *Resources.* The maximum allowed household asset limit for the program is $15,000. Resources shall be counted in accordance with Iowa Code section 239.4(1).

48.2(3) *Income.* The household's gross countable monthly income determined according to 441—Chapter 65 must be less than or equal to 160 percent of the current federal poverty guidelines for the household size. The income eligibility limits as described in this subrule are revised each October 1 to reflect the annual adjustment to the federal poverty guidelines.

48.2(4) *Otherwise eligible for SNAP.* The household must meet all eligibility criteria for SNAP except as provided in this rule. A household that includes a member who is currently disqualified from SNAP due to an intentional program violation is not eligible for the program.

48.2(5) *Minimum SNAP benefit.* The household must be eligible for a monthly SNAP benefit greater than zero. Households with a monthly SNAP benefit of zero are not eligible for the program.

[**ARC 9065C**, IAB 4/2/25, effective 6/1/25]

441—48.3(234) Notice and eligibility period. A household that meets all of the eligibility criteria in this chapter will receive written notice of its eligibility for the promoting awareness of the benefits of a healthy marriage program.

48.3(1) *Written information.* Households determined eligible for the program will receive written information about the benefits of a healthy and stable marriage.

48.3(2) *Eligibility period.* A household that is determined eligible for the program will remain eligible for the program until the earlier of the following events:

a. The household fails to meet the eligibility criteria under this chapter, or

b. The household's SNAP certification period under 441—Chapter 65 ends.

[**ARC 9065C**, IAB 4/2/25, effective 6/1/25]

These rules are intended to implement Iowa Code section 234.6.

[Filed ARC 9065C (Notice ARC 8709C, IAB 1/8/25), IAB 4/2/25, effective 6/1/25]

CHAPTER 49
FAMILY DEVELOPMENT AND SELF-SUFFICIENCY (FaDSS) PROGRAM

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

441—49.1(216A) Definitions. As used in these rules, unless the context otherwise requires:

"Applicant" means a public or private organization that applies for a family development and self-sufficiency grant through the request for proposal process.

"Council" means the council on health and human services.

"Grant" means an award approved by the council to fund a family development and self-sufficiency project.

"Grantee" means an applicant whose proposal is selected by the council and who enters into a grant agreement with the department.

"Program" or *"FaDSS program"* means the family development and self-sufficiency (FaDSS) program.

"Proposal" or *"grant proposal"* means an application for grant funds to fund specific projects.

[**ARC 9147C**, IAB 4/30/25, effective 7/1/25]

441—49.2(216A) Identification of conditions and criteria for families at risk. The council has identified the following conditions and criteria that may place families at risk of instability or of long-term dependency on the family investment program:

49.2(1) *Educational level of head of household.*

a. Head of household has less than a high school education.

b. Head of household lacks basic literacy skills.

49.2(2) *Work experience of head of household.*

a. Head of household has never been employed.

b. Head of household has multiple episodes of employment lasting less than one year.

c. Head of household is currently unemployed.

49.2(3) *Household composition.*

a. Members are homeless or nearly homeless.

b. Members outside the nuclear family are in residence.

c. One or more children in the household were born while the parent received public assistance.

d. One or more children in the household are identified as having special needs.

e. Household includes a family member with substantiated substance use issues.

f. Household includes a past or current perpetrator of child abuse or domestic violence.

g. Household includes a member with a record of incarceration.

49.2(4) *Background of head of household.*

a. Head of household was a teenager at birth of first child.

b. Head of household has a disability or chronic illness (mental or physical).

c. Head of household is a past or current victim of child abuse or domestic violence.

d. Head of household grew up in a household with substance abuse.

49.2(5) *Public assistance history.*

a. Head of household grew up in a household that received public assistance.

b. Household has experienced multiple episodes of receipt of public assistance.

c. Household has been on public assistance for three or more years.

49.2(6) *Other conditions.* The council has also identified the following conditions that may contribute to instability or long-term dependency:

a. Lack of employment opportunity.

b. Lack of available services.

c. Lack of transportation.

[**ARC 9147C**, IAB 4/30/25, effective 7/1/25]

441—49.3(216A) Referral of families. Families who meet one or more of the conditions and criteria identified in rule 441—49.2(216A) may be referred to the program by the department, the department of workforce development, family self-referral, or other sources. Grantees will determine eligibility for the program in accordance with the eligibility criteria determined by the department.
[**ARC 9147C**, IAB 4/30/25, effective 7/1/25]

441—49.4(216A) Funding of grants.

49.4(1) *Availability of funds.* The council will develop requests for proposals for the awarding of grants, subject to availability of funds. Grants will not exceed 60 months; however, the department will approve grantee budgets on an annual basis, based upon and subject to available funds.

49.4(2) *Grant application process.* The department will distribute applications for grants through a request for proposal. Applications shall be submitted to the department in accordance with the instructions indicated in the request for proposal.

49.4(3) *Grant proposals.* Grant proposals for the program must include all elements outlined in the application as determined by the council.

49.4(4) *Selection of grant proposals.* All proposals timely received will be reviewed by the department, which will make recommendations to the council. The council will review the projects recommended by the department and make the final decision with respect to grant awards.

49.4(5) *Notification of applicants.* Applicants will be notified of grant award decisions within 60 days after the due date for receipt of proposals.
[**ARC 9147C**, IAB 4/30/25, effective 7/1/25]

441—49.5(216A) Grants not renewed and grants terminated or reduced. If the council determines that a grantee's project funding will not be renewed or if the council terminates or reduces a grantee's funding, the balance of funds not renewed or terminated or reduced will be awarded by the council to other grantees for which funding is approved, based on criteria approved by the council. In the event no previously approved grantees have been selected, the council will fund new grantees selected by the council as a result of a competitive grant application process.
[**ARC 9147C**, IAB 4/30/25, effective 7/1/25]

441—49.6(216A) Appeal.

49.6(1) Applicants dissatisfied with the council's actions regarding grant proposals for funds and grantees dissatisfied with termination of a contract may appeal the council's decision in accordance with 441—Chapter 2506.

49.6(2) In the case of a grant award, no disbursements will be made to a grantee for a period of ten calendar days following issuance of the notice of decision to award. If an appeal is filed within the ten days, all disbursements will be held pending a final decision on the appeal. All applicants will be notified if an appeal is filed.
[**ARC 9147C**, IAB 4/30/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—49.7(216A) Contract with grantee. Funds for grants approved by the council will be awarded pursuant to a contract entered into by the department and the grantee.

49.7(1) *Negotiation.* The department will conduct contract negotiations with the selected applicant, including negotiations regarding possible modifications to a grant proposal.

49.7(2) *Withdrawal of contract offer.* If the applicant and the department are unable to successfully negotiate a contract, the council may withdraw the award offer and award the grant to the applicant with the next highest-scoring proposal.

49.7(3) *Contract revisions.* The department and the grantee may negotiate revisions to the contract to allow for nonmaterial expansion or modification of services so long as such revisions do not increase the total amount of the grant. The department has the right to approve an amendment to the contract budget moving grant funds between budget line items if the funds represent more than 10 percent of the budget line item. All contract amendments will be granted at the discretion of the department in accordance with the terms set forth in the contract.
[**ARC 9147C**, IAB 4/30/25, effective 7/1/25]

441—49.8(216A) Grantee responsibilities. The grantee will be responsible for providing services in accordance with the policies and procedures set forth in the FaDSS program manual as amended to August 1, 2024; the grant contract; and any other guidance from the department.
[**ARC 9147C**, IAB 4/30/25, effective 7/1/25]

441—49.9(216A) Evaluation. The grantee will be evaluated by the department in accordance with the continuous quality improvement plan developed by the department.
[**ARC 9147C**, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 216A.107.

[Filed ARC 9147C (Notice ARC 8535C, IAB 12/11/24), IAB 4/30/25, effective 7/1/25]
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TITLE V
STATE SUPPLEMENTARY ASSISTANCE

CHAPTER 50
APPLICATION FOR ASSISTANCE

[Prior to 7/1/83, Social Services[770] Ch 50]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/2/30

441—50.1(249) Definitions.

"Aged" means a person 65 years of age or older.

"Applicant" means a person who is requesting state supplementary assistance on the person's own behalf or a person for whom state supplementary assistance is requested.

"Blind" means the same as defined in 20 CFR Section 416.981 as amended to August 1, 2024.

"Client" means a person who has been determined eligible and is a current or former recipient of state supplementary assistance.

"Disabled" means the same as defined in 20 CFR Section 416.905 or 20 CFR Section 416.906, both as amended to August 1, 2024. Exception: For the supplement for Medicare and Medicaid eligibles, being engaged in substantial gainful activity will not preclude a determination of disability. For purposes of state-administered payments, the department will determine disability according to 441—Chapter 75.

"Payment for a dependent relative" means a payment to a recipient on behalf of a dependent relative as defined in Iowa Code section 249.3(3).

"Payment for a protective living arrangement" means a payment to a recipient living in a family life home.

"Payment for residential care" means a payment to a recipient living in a residential care facility who is determined to be in need of care and payment is made on a per diem basis.

[**ARC 9304C**, IAB 5/28/25, effective 7/2/25]

441—50.2(249) Application procedures.

50.2(1) In order to be eligible for state supplementary assistance, an aged, blind, or disabled person with need for a living arrangement as defined in Iowa Code section 249.3 shall be receiving supplemental security income benefits or shall meet all eligibility requirements for the benefits other than income, but have less income than the standards for the living arrangements as set forth in 441—Chapter 52 and 441—Chapter 177.

a. Payments for mandatory supplementation, blind allowance, dependent relative allowance, and the family life home program shall be federally administered. Income excluded in determining eligibility for or the amount of a supplemental security income benefit will be excluded in determining eligibility for or the amount of the state payment.

b. Payments for in-home, health-related care and residential care shall be state-administered. Income excluded in determining eligibility for or the amount of a supplemental security income benefit, except the $20 exclusion of any income, will be excluded in determining eligibility for or the amount of the state payment.

c. Payments for supplements for Medicare and Medicaid eligibles shall be state-administered. Income excluded in determining eligibility for the person's Medicaid coverage group will be excluded in determining eligibility for the state payment.

50.2(2) Any person applying for payment for a protective living arrangement or payment for a dependent relative shall make application for supplemental security income at the Social Security Administration district office. The county office of the department will certify to the Social Security Administration as to the nature of the living arrangement or the status of the dependent.

50.2(3) Any person applying for payment for residential care, a dependent person allowance, payment for a protective living arrangement, or in-home health-related care shall make application with the department. The application shall be made on a form prescribed by the department. The application shall be

signed by the applicant or the authorized representative. Someone acting responsibly for an incapacitated, incompetent, or deceased person may sign the application on the person's behalf.

a. Each person wishing to do so shall have the opportunity to apply for assistance without delay.

b. An applicant may be assisted by an authorized representative as defined in rule 441—76.1(249A). If the applicant is unable to act on the applicant's own behalf, a responsible person may act on the applicant's behalf pursuant to rule 441—76.9(249A).

c. The department will notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or refusal to authorize the department to secure the information from other sources shall serve as a basis for denial of assistance.

50.2(4) An application for Medicaid from a person who meets the requirements of rule 441—51.6(249) will be considered as an application for the supplement for Medicare and Medicaid eligibles.

[**ARC 9304C**, IAB 5/28/25, effective 7/2/25]

441—50.3(249) Approval of application and effective date of eligibility.

50.3(1) Payment for a federally administered payment category when the applicant is not a supplemental security income (SSI) recipient will be effective the month following the month that an application is filed or, if later, the month following the month that all eligibility criteria are met, pursuant to 42 U.S.C. Section 1382(c)(7) as amended to August 1, 2024. Payment for a federally administered payment category when the applicant is an SSI recipient will be effective as of the first day of the month in which an application is filed or the first day of the month in which all eligibility criteria are met, whichever is later, notwithstanding 42 U.S.C. Section 1382(c)(7) as amended to August 1, 2024.

50.3(2) Payment for residential care will be effective as of the date that eligibility first exists, notwithstanding 42 U.S.C. Section 1382(c)(7) as amended to August 1, 2024, but in no case will the effective date be earlier than 30 days prior to the date of application.

50.3(3) The application for residential care will be approved or denied within five working days after the Social Security Administration approves supplemental security income benefits. When supplemental security income benefits will not be received, the application will be approved or denied within five working days from the date of establishment of all eligibility factors.

50.3(4) Payment for the supplement for Medicare and Medicaid eligibles will be effective retroactive to October 1, 2003, or to the first month when all eligibility requirements are met, whichever is later.

[**ARC 9304C**, IAB 5/28/25, effective 7/2/25]

441—50.4(249) Reviews.

50.4(1) Any eligibility factor will be reviewed whenever a change in circumstances occurs.

50.4(2) All eligibility factors will be reviewed at least annually.

50.4(3) For purposes of an annual review to be performed by the department, the client shall complete and return a form prescribed by the department.

[**ARC 9304C**, IAB 5/28/25, effective 7/2/25]

441—50.5(249) Application under conditional benefits. When the applicant or client is seeking state supplementary assistance (SSA) under the conditional benefit policy of the SSI program in accordance with 20 CFR Section 416.1242 as amended to March 15, 2022, the applicant or client are required to do the following:

50.5(1) Complete and return Form 470-2909.

50.5(2) Complete and return Form 470-2908 as follows:

a. For personal property, every 30 days during the conditional benefits period.

b. For real property, 35 days after conditional benefits are granted and every 60 days thereafter for nine months. If eligibility continues and the real property is not sold, the applicant or client shall complete the form every 90 days.

50.5(3) Sign an agreement to repay the state supplementary assistance granted during the conditional period using a form prescribed by the department. The amount of repayment is limited to the lesser of:

a. The amount by which the revised value of resources (resources counted at the beginning of the conditional period plus the net value of resources sold) minus both the resource limit and the amount that SSI recovers for conditional benefits.

b. The amount of state supplementary assistance actually paid in the conditional period, minus the amount that SSI recovers for conditional benefits.

[**ARC 9304C**, IAB 5/28/25, effective 7/2/25]

These rules are intended to implement Iowa Code sections 249.3, 249.4 and 249A.4.

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CHAPTER 51
ELIGIBILITY
[Prior to 7/1/83, Social Services[770] Ch 51]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—51.1(249) Definitions.

"Administrative overpayment" means assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

"Agency error" means assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the local office.
6. Failure to make prompt revisions in payment following changes in policies requiring the changes as of a specific date.

"Client" means a person who has been determined eligible and is a current or former recipient of state supplementary assistance.

"Client error" means assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report changes as described in 441—Chapter 76.

[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.2(249) Application for other benefits. An applicant or any other person whose needs are included in determining the state supplementary assistance payment must have applied for or be receiving all other benefits, including supplemental security income or the family investment program, for which the person may be eligible. The person must cooperate in the eligibility procedures while making application for the other benefits. Failure to cooperate shall result in ineligibility for state supplementary assistance.

[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.3(249) Supplementation. Any supplemental payment made on behalf of the recipient from any source other than a nonfederal governmental entity will be considered as income, and the payment will be used to reduce the state supplementary assistance payment.

[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.4(249) Eligibility for residential care.

51.4(1) *Licensed facility.* Payment for residential care can only be made when the facility in which the applicant or recipient is residing is currently licensed by the department of inspections, appeals, and licensing pursuant to laws governing health care facilities.

51.4(2) *Physician's statement.* Payment for residential care must be made only when there is on file an order written by a physician certifying that the applicant or recipient being admitted requires residential care but does not require nursing services. The certification will be updated whenever a change in the recipient's physical condition warrants reevaluation, but no less than every 12 months.

51.4(3) *Income eligibility.* The resident is income eligible when the income according to 441—paragraph 52.1(3)*"a"* is less than 31 times the maximum per diem rate. Partners in a marriage who both enter the same room of the residential care facility in the same month will be income eligible for

the initial month when their combined income according to 441—paragraph 52.1(3)*"a"* is less than twice the amount of allowed income for one person (31 times the maximum per diem rate).
[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.5(249) Dependent relatives.

51.5(1) *Income.* Income of a dependent relative must be less than the amount established by the department based on assistance standards as provided in rule 441—52.1(249). When the dependent's income is from earnings, an exemption of $65 will be allowed to cover work expense.

51.5(2) *Resources.* The resource limitation for a recipient and a dependent child or parent is $2,000. The resource limitation for a recipient and a dependent spouse is $3,000. The resource limitation for a recipient, spouse, and dependent child or parent is $3,000.

51.5(3) *Living in the home.* A dependent relative is eligible until the dependent relative is out of the recipient's home for a full calendar month starting at 12:01 a.m. on the first day of the month until 12 midnight on the last day of the same month.

51.5(4) *Dependency.* A dependent relative may be the recipient's ineligible spouse, parent, child, or adult child who is financially dependent upon the recipient. A relative will not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.
[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.6(249) Residence. A recipient of state supplementary assistance must be living in the state of Iowa.
[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.7(249) Eligibility for supplement for Medicare and Medicaid eligibles. The following eligibility requirements are specific to the supplement for Medicare and Medicaid eligibles:

51.7(1) *Medicaid eligibility.* The recipient must be eligible for and receiving full medical assistance benefits under Iowa Code chapter 249A without regard to eligibility based on receipt of state supplementary assistance under this rule, and without being required to meet a spend down or pay a premium to be eligible for medical assistance benefits.

51.7(2) *SSI eligibility.* The recipient must meet all eligibility requirements for supplemental security income benefits other than limits on substantial gainful activity and income.

51.7(3) *Not otherwise eligible.* The recipient must not be eligible for benefits under another state supplementary assistance group.

51.7(4) *Medicare eligibility.* The recipient must be currently eligible for Medicare Part B.

51.7(5) *Living arrangement.* A recipient may live in one of the following:

a. The person's own home.

b. The home of another person.

c. A group living arrangement.

d. A medical facility.

51.7(6) *Income.* Income of a recipient must be within the income limit for the person's Medicaid eligibility group, but must exceed 120 percent of the federal poverty level.
[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.8(249) Income from providing room and board. In determining income from furnishing room and board or providing family-life home care, the amount established by the department based on assistance standards as provided in rule 441—52.1(249) will be deducted to cover the cost, and the remaining amount will be treated as earned income.
[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.9(249) Furnishing of social security number.

51.9(1) As a condition of eligibility, applicants or recipients of state supplementary assistance must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

51.9(2) Assistance will not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

[**ARC 9305C**, IAB 5/28/25, effective 8/1/25]

441—51.10(249) Recovery.

51.10(1) *Amount subject to recovery.* The department will recover from a client all state supplementary assistance funds incorrectly expended to or on behalf of the client, or when conditional benefits have been granted.

a. The department will seek to recover the state supplementary assistance granted during the period of time that conditional benefits were correctly granted the client under the policies of the supplemental security income program.

b. The incorrect expenditures may result from client or agency error, or administrative overpayment.

51.10(2) *Notification.* All clients will be promptly notified when it is determined that assistance was incorrectly expended. Notification will include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery, when known; and the reason for the incorrect expenditure.

51.10(3) *Source of recovery.* Recovery will be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery must come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

51.10(4) *Repayment.* The repayment of incorrectly expended state supplementary assistance funds will be made to the department.

51.10(5) *Appeals.* The client has the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 2506.

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These rules are intended to implement Iowa Code sections 249.3 and 249.4.

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CHAPTER 52
PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 52]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—52.1(249) Assistance standards. Assistance standards are the amounts of money allowed on a monthly basis to recipients of state supplementary assistance in determining financial need and the amount of assistance granted. Current assistance standards will be published on the department's website. Assistance standards will be adjusted annually to reflect cost-of-living adjustments (COLA) adopted by the Social Security Administration, in accordance with 20 CFR §416.2095 and 20 CFR §416.2096 as amended to March 15, 2022. Adjustments to the assistance standards based on COLA are effective January 1 of each year.

52.1(1) *Protective living arrangement.* Assistance standards will be established by the department as provided in this chapter for care and personal allowances for persons living in a family-life home certified under rules in 441—Chapter 111.

52.1(2) *Dependent relative.* Assistance standards for the following categories will be established by the department as provided in this chapter for state supplementary assistance for dependent relatives residing in a recipient's home.

a. Aged or disabled client and a dependent relative.

b. Aged or disabled client, eligible spouse, and a dependent relative.

c. Blind client and a dependent relative.

d. Blind client, aged or disabled spouse, and a dependent relative.

e. Blind client, blind spouse, and a dependent relative.

52.1(3) *Residential care.* For periods of eligibility before July 1, 2017, the department will reimburse a recipient in either a privately operated or non-privately operated residential care facility on a flat per diem rate or on a cost-related reimbursement system with a maximum per diem rate established consistent with the assistance standards principles provided in this chapter.

For periods of eligibility beginning July 1, 2017, and thereafter, payment to a recipient in a licensed residential care facility will be based on the maximum per diem rate.

The facility shall accept the per diem rate established by the department for state supplementary assistance recipients as payment in full from the recipient and make no additional charges to the recipient.

a. All income of a recipient as described in this subrule after the disregards described in this subrule will be applied to meet the cost of care before payment is made through the state supplementary assistance program.

Income applied to meet the cost of care will be the income considered available to the resident pursuant to supplemental security income (SSI) policy plus the SSI benefit less the following monthly disregards applied in the order specified:

(1) When income is earned, impairment-related work expenses, as defined by SSI plus $65 plus one-half of any remaining earned income.

(2) An allowance established by the department consistent with this chapter will be given to meet personal expenses and Medicaid copayment expenses.

(3) When there is a spouse at home, the amount of the SSI benefit for an individual minus the spouse's countable income according to SSI policies. When the spouse at home has been determined eligible for SSI benefits, no income disregard will be made.

(4) When there is a dependent child living with the spouse at home who meets the definition of a dependent according to the SSI program, the amount of the SSI allowance for a dependent minus the dependent's countable income and the amount of income from the parent at home that exceeds the SSI benefit for one according to SSI policies.

(5) Established unmet medical needs of the resident, excluding private health insurance premiums and Medicaid copayment expenses. Unmet medical needs of the spouse at home, exclusive of health insurance

premiums and Medicaid copayment expenses, will be an additional deduction when the countable income of the spouse at home is not sufficient to cover those expenses. Unmet medical needs of the dependent living with the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, will also be deducted when the countable income of the dependent and the income of the parent at home that exceeds the SSI benefit for one is not sufficient to cover the expenses.

(6) The income of recipients of state supplementary assistance or Medicaid needed to pay the cost of care in another residential care facility, a family-life home, an in-home health-related care provider, a home- and community-based waiver setting, or a medical institution is not available to apply to the cost of care. The income of a resident who lived at home in the month of entry will not be applied to the cost of care except to the extent the income exceeds the SSI benefit for one person or for a married couple if the resident also had a spouse living in the home in the month of entry.

b. Payment is made for only the days the recipient is a resident of the facility. Payment must be made for the date of entry into the facility, but not the date of death or discharge.

c. Payment must be made in the form of a grant to the recipient on a post payment basis.

d. Payment must not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the recipient shall remain eligible for all other benefits of the program.

e. Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 30 days during any calendar year unless a family member or legal guardian of the resident, the resident's physician, case manager, or department service worker provides signed documentation that additional visitation days are desired by the resident and are for the benefit of the resident. This documentation shall be obtained by the facility for each period of paid absence that exceeds the 30-day annual limit. This information must be retained in the resident's personal file. If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a Case Activity Report, on a form prescribed by the department, to the county office of the department to terminate the state supplementary assistance payment.

A family member may contribute to the cost of care for a resident subject to supplementation provisions detailed in rule 441—51.2(249) and any contributions shall be reported to the county office of the department by the facility.

f. Payment will be made for a period not to exceed 20 days in any calendar month when the resident is absent due to hospitalization. A resident may not start state supplementary assistance on reserve bed days.

52.1(4) *Blind.* The standard for a blind recipient not receiving another type of state supplementary assistance is $22 per month.

52.1(5) *In-home, health-related care.* Payment to a person receiving in-home, health-related care must be made in accordance with rules in 441—Chapter 177.

52.1(6) *Minimum income level cases.* The income level of those persons receiving old age assistance, aid to the blind, and aid to the disabled in December 1973 shall be maintained at the December 1973 level as long as the recipient's circumstances remain unchanged and that income level is above current standards. In determining the continuing eligibility for the minimum income level, the income limits, resource limits, and exclusions that were in effect in October 1972 shall be utilized.

52.1(7) *Supplement for Medicare and Medicaid eligibles.* Payment to a person eligible for the supplement for Medicare and Medicaid eligibles shall be $1 per month.

This rule is intended to implement Iowa Code chapter 249.

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CHAPTER 53
RENT SUBSIDY PROGRAM
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CHAPTER 54
FACILITY PARTICIPATION

[Prior to 7/l/83, Social Services[770] Ch 54]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—54.1(249) Application and contract agreement. Each facility desiring to participate in the state supplementary assistance program must enter into a contract with the department and agree to the provisions set forth in a contract in a form prescribed by the department. The effective date of the contract shall be the first of the month that the form is signed by the administrator of the facility and is received by the department. No payment shall be made for care provided before the effective date of the contract. The contract shall be in effect until the department ceases to participate in the program, until either party gives 60 days' notice of termination in writing to the other party, or until there is a change in ownership. The facility shall notify the department within 30 days of a change in ownership, a change in the number of beds, or a change in administrator.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 9307C**, IAB 5/28/25, effective 8/1/25]

441—54.2(249) Maintenance of case records. A facility must maintain a case folder for each individual residing in the facility that contains the following:

1. Contract between the facility and the resident on a form prescribed by the department.
2. Physician's statement certifying that the resident does not require nursing services.
3. Proof of expenditures from resident's "personal needs" allowance.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 9307C**, IAB 5/28/25, effective 8/1/25]

441—54.3(249) Payments for residential care facilities. Payments for residential care facilities will be made at the maximum per diem rate in 441—subrule 52.1(3).

54.3(1) *Failure to maintain records.* Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility, may result in the penalties specified in rule 441—79.3(249A).

54.3(2) *Termination or change of ownership.* A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 9307C**, IAB 5/28/25, effective 8/1/25]

441—54.4(249) Goods and services provided. All facilities participating in the program shall provide residents those goods and services required by the terms of the license issued by the department of inspections, appeals, and licensing in accordance with Iowa Code chapter 135C and rules promulgated thereto set forth in 481—Chapter 57 and requirements of the department set forth in these rules.

54.4(1) *Payment accepted.* The amount of client participation and the payment made through the state supplementary assistance program shall be accepted as payment in full for the required goods and services provided to the resident. The facility may seek reimbursement from other sources for goods and services provided that are beyond the goods and services required to be provided by these rules.

54.4(2) *Care, maintenance, general supervision, and personal services.* Each facility, as part of providing care, maintenance, general supervision, and personal services, shall provide as necessary supervision or assistance with ambulation, grooming, hair washing, shaving, personal hygiene, bathing, getting in and out of bed, dressing, feeding, and medication that can be self-administered.

54.4(3) *Laundry.* Each facility shall provide personal laundry service to the resident as part of the goods and services paid for through the program.

54.4(4) *Room furnishings.* The facility shall completely furnish the resident's room in accordance with 481—subrule 57.30(4) without additional charge to the resident or person acting on the resident's behalf. When the resident wishes to provide some item or items of room furnishing, the facility may grant the request.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 9307C**, IAB 5/28/25, effective 8/1/25]

441—54.5(249) Personal needs account. When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The personal needs funds shall be deposited in a single checking account, not commingled with trust funds from any other facility, nor commingled with facility operating funds except for facility funds, not to exceed $500, deposited to cover bank charges and have in the account name the terms "Resident Trust Funds." The funds shall be deposited in a bank or other institution within the state of Iowa insured by the federal government. Expense for bank service charges for this account is a cost of doing business if the service cannot be obtained free of charge. The department will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs allowance when such charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

54.5(1) *Ledger.* Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

54.5(2) *Expenditures.* When something is purchased for the resident and is not a direct cash disbursement, each such expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

54.5(3) *Disbursement.* Personal funds shall be turned over only to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give the consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

54.5(4) *Audit.* The ledger and receipts for each recipient shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

54.5(5) *Death.* Upon a recipient's death, the funds remaining in the personal needs account shall be treated in the following manner:

a. The facility shall provide a written statement of the personal needs account to be filed in the case record.

b. When an estate is opened, the funds shall be submitted to the estate administrator.

c. When no estate is opened, the funds shall be released to the person assuming responsibility for the recipient's funeral expenses.

d. When no estate is opened and there are no living heirs, the funds shall be submitted to the department to escheat to the state.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 9307C**, IAB 5/28/25, effective 8/1/25]

441—54.6(249) Case activity report. Whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility, the facility shall notify the department on a form prescribed by the department.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 9307C**, IAB 5/28/25, effective 8/1/25]

441—54.7(249) Billing procedures. In order to determine the amount of payment to the recipient, the facility shall submit a billing form to the department following the month in which service was provided.

This rule is intended to implement Iowa Code section 249.12.

[**ARC 9307C**, IAB 5/28/25, effective 8/1/25]

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TITLE VI
GENERAL PUBLIC ASSISTANCE PROVISIONS

CHAPTER 55
WORK AND TRAINING PROGRAMS

[Prior to 7/1/83, Social Services[770] Ch 55]
[Prior to 2/11/87, Human Services[495]]
Rescinded, effective 7/1/89, see 441—Chapter 93

CHAPTER 56
BURIAL BENEFITS

[Prior to 7/1/83, Social Services[770] Ch 56]
[Prior to 2/11/87, Human Services[498]]
Rescinded IAB 2/6/02, effective 4/1/02

CHAPTER 57
INTERIM ASSISTANCE REIMBURSEMENT
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—57.1(249) Definitions.

"Benefits" means Supplemental Security Income (SSI) for the aged, blind, and disabled (a federal cash assistance program under Title XVI of the Social Security Act as amended to August 1, 2024) and any federally administered state supplementary assistance payments that are determined by the Social Security Administration to be due an individual at the time the SSI payment is made.

"County agency" means a county or county subdivision under the jurisdiction of the county board of supervisors, including a county commission of veteran affairs, that furnishes relief in the form of cash or vendor payments to or on behalf of needy persons in accordance with established standards under the provisions of Iowa Code chapter 35B or 252.

"Initial payment" means the amount of benefits determined by the Social Security Administration to be payable to an eligible person (including any retroactive amounts) when the person is first determined to be eligible for SSI. The initial payment does not include any emergency advance payments, any presumptive disability or blindness payments, or any immediate payments authorized under Section 1631 of the Social Security Act as amended to August 1, 2024.

"Initial posteligibility payment" means the amount of benefits determined by the Social Security Administration to be payable to an eligible person (including any retroactive amounts) when the person is first determined eligible for SSI following a period of suspension or termination. The initial posteligibility payment does not include any emergency advance payments, any presumptive disability or blindness payments, or any immediate payments authorized under Section 1631 of the Social Security Act as amended to August 1, 2024.

"Interim assistance" means the same as defined in 20 CFR Part 416 as amended to August 1, 2024.

"Interim period" means either (1) the period beginning with the month following the month in which a person filed an application for benefits for which the person was found to be eligible and ending with and including the month the person's benefits began, or (2) the period beginning the day the person's benefits were reinstated after a period of suspension or termination, and ending with (and including) the month the person's benefits were resumed. The interim period does not include any periods during which the person is underpaid by the Social Security Administration due to that agency's failure to make a timely modification of the person's SSI benefit or for any other reason.

[**ARC 9308C**, IAB 5/28/25, effective 8/1/25]

441—57.2(249) Requirements for reimbursement. In order to receive reimbursement for interim assistance payments, a county agency must meet the following requirements:

57.2(1) *Agreement.* The county agency shall enter into a written agreement with the department of health and human services on a form prescribed by the department.

57.2(2) *Authorization.* The county agency shall secure written authorization from the person seeking interim assistance. By signing a form prescribed by the department, the person:

a. Indicates the intent to apply for SSI benefits.

b. Authorizes the Social Security Administration to:

(1) Withhold the amount of interim assistance from the person's initial payment or initial posteligibility payment, and

(2) Make this amount payable to the county agency.

57.2(3) *Records.* The county agency shall:

a. Maintain a file for each person who has received interim assistance.

b. Maintain adequate records of all transactions made relating to interim assistance.

c. Comply with the provisions of the Federal Information Security Management Act (FISMA) as amended to August 1, 2024; 20 CFR Part 401 as amended to August 1, 2024; and the Privacy Act of 1974

as amended to August 1, 2024, relating to the safeguarding of information concerning individuals who have applied for interim assistance.

[**ARC 9308C**, IAB 5/28/25, effective 8/1/25]

441—57.3(249) Certificate of authority.

57.3(1) The county agency shall submit the information requested on a form prescribed by the department to the Social Security Administration at the address given on the form:

a. Before the date the agency first participates in the program, and

b. Subsequently when changes in the list of authorized officials occur.

57.3(2) The county agency shall submit a copy of the form referenced in subrule 57.3(1) to the department at the address given on the form each time the form is submitted to the Social Security Administration.

[**ARC 9308C**, IAB 5/28/25, effective 8/1/25]

These rules are intended to implement 1984 Iowa Acts, chapter 1310, section 9.

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CHAPTER 58
COMMUNITY SERVICES BLOCK GRANT (CSBG)

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/31

441—58.1(216A,PL97-35) Definitions. For the purpose of these rules, unless context otherwise requires:

"Community action agency" or *"eligible entity"* means any organization that was officially recognized as a community action agency under the provisions of Section 673(1) of the CSBG Act and Iowa Code sections 216A.91 and 216A.93.

"CSBG" means community services block grant program.

"CSBG Act" means the Omnibus Budget Reconciliation Act of 1981, PL 97-35, Title VI, Subtitle B, as amended to August 1, 2026. All references to the CSBG Act herein are as amended to August 1, 2026.

"Program year" means the year beginning October 1 and ending the succeeding September 30. The program year is numbered for that year in which it ends.

"Reduction" means funding reduced below the proportional share of funding the eligible entity received in the previous program year.

"Termination" means permanent withdrawal of the eligible entity's authority to obligate funds before that authority would otherwise expire. If an eligible entity's authority to obligate funds is terminated, no funds may be obligated by the eligible entity after the effective date of the termination.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.2(216A,PL97-35) Purposes. The CSBG as established by the CSBG Act provides assistance to states and local communities, working through a network of community action agencies and other neighborhood-based organizations, for the reduction of poverty, the revitalization of low-income communities, and the empowerment of low-income families and individuals in rural and urban areas to become self-sufficient.

Pursuant to Iowa Code section 216A.92, the department administers the community services block grant.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.3(216A,PL97-35) Uses of funds. The CSBG makes available to the state of Iowa funds to be used:

58.3(1) To support the following activities that are designed to assist low-income families and individuals:

a. Removing obstacles and solving problems that block the achievement of self-sufficiency;

b. Securing and retaining meaningful employment;

c. Attaining an adequate education;

d. Making better use of available income;

e. Obtaining and maintaining adequate housing and a suitable living environment;

f. Obtaining emergency assistance through loans, grants, or other means to meet immediate and urgent family and individual needs; and

g. Achieving greater participation in the affairs of the communities involved.

58.3(2) To address the needs of youth in low-income communities through youth development programs.

58.3(3) To make more effective use of, and to coordinate with, other programs related to the purposes of this program.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.4(216A,PL97-35) Apportionment distribution.

58.4(1) *Iowa apportionment.* There are appropriated to the department from the fund created by Iowa Code section 8.41(1) funds to implement the CSBG as described in the CSBG Act.

58.4(2) *Distribution of funds.* CSBG funds received according to subrule 58.4(1) will be allocated to the department and eligible entities as provided by federal law and in accordance with Iowa law.

58.4(3) *Poverty-level population.* The state will use U.S. census statistics to determine the poverty-level population in each community action area.

58.4(4) *Local share.* There shall be no local share required under the CSBG.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.5(216A,PL97-35) Eligibility requirements. The eligibility requirements for an organization to receive and administer CSBG funds are as follows.

58.5(1) *Organization.* The organization must meet the definition of a "community action agency" as defined in these rules.

58.5(2) *Board composition.* A recognized community action agency shall be governed by a board of directors composed of at least nine members. The board membership shall follow the requirements in Iowa Code section 216A.94.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.6(216A,PL97-35) Community action plan. All eligible entities shall submit a community action plan for the purpose of applying for CSBG funds. Community action plans must be outcome-based and antipoverty-focused and tie directly to the eligible entity's community assessment.

58.6(1) *Timing.* Eligible entities shall be informed in writing by the department of the due date for the community action plan and the amount of the eligible entities' allocation in accordance with subrule 58.4(2).

58.6(2) *Contents.* The department will provide instructions for preparing the community action plan to all eligible entities. In addition to other information specified in the instructions, the community action plan must:

a. Document the continuous use of the full federal model for the Results Oriented Management and Accountability cycle of assessment, planning, implementation, achievement of results, and evaluation for planning and administering the CSBG;

b. Include a budget that equals the amount of the eligible entity's allocation;

c. Include a description of the service delivery system targeted to low-income individuals and families in the service area;

d. Include a description of how linkages will be developed to fill identified gaps in the services through the provision of information, referrals, case management, and follow-up consultations;

e. Include a description of how CSBG funds will be coordinated with other public and private resources;

f. Include a description of how CSBG funds will be used to support innovative community and neighborhood-based initiatives related to the purposes in rule 441—58.2(216A,PL97-35); and

g. Include outcome measures to be used to measure eligible entity performance in promoting self-sufficiency, family stability, and community revitalization.

58.6(3) *Nondiscrimination provisions.* Eligible entities must ensure that no person shall, on the basis of race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any activity funded in whole or in part with CSBG funds.

58.6(4) *Community assessment.* Eligible entities must conduct a community assessment at least once every three years. The community assessment shall include data specific to poverty, qualitative and quantitative data, and key findings on the causes and conditions of poverty and the needs of the communities assessed. The results of the assessment shall be used to plan activities contained in the community action plan.

58.6(5) *Contract.* The department will issue the eligible entity a CSBG contract once the department accepts the community action plan.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.7(216A,PL97-35) Review and acceptance of community action plans.

58.7(1) *Compliance review.* All activities proposed in the community action plan will be reviewed by the department for:

a. Compliance with the specific purposes and uses of funds outlined in rules 441—58.2(216A,PL97-35) and 441—58.3(216A,PL97-35);

b. Inclusion of assurances that the eligible entity will conduct the CSBG in compliance with all applicable laws; and

c. Inclusion and proper completion of all forms and instructions included in the request for community action plans.

58.7(2) *Performance.* Acceptance of community action plans is dependent on the satisfactory performance of the eligible entity in the past funding year(s). Additionally, available records, audits, and determinations from other relevant state and federal agencies may be utilized.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.8(216A,PL97-35) Ineligible items. CSBG funds cannot be used for the following activities or costs:

58.8(1) Any partisan or nonpartisan political activity or any political activity associated with a candidate, or faction group, in an election for public or party office; any activity to provide voters or prospective voters with transportation to the polls or similar assistance in connection with any such election; or any voter registration activity.

58.8(2) The purchase or improvement of land, or the purchase, construction, or permanent improvement (other than low-cost residential weatherization or other energy-related home repairs) of any building or other facility. Exceptions shall only be provided through the waiver procedure described in Section 678F(a) of the CSBG Act.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.9(216A) Audits and records. Eligible entities shall arrange and pay for an annual audit. Audits shall be performed by a certified public accountant and in accordance with generally accepted auditing standards. Audit procedures shall conform to 2 CFR Chapter I, Office of Management and Budget Governmentwide Guidance for Grants and Agreements as amended to August 1, 2026, and Chapter II, Part 200, et al., Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards as amended to August 1, 2026. In addition, the department may request more frequent audits or examinations of financial records of the eligible entity in order to ensure adequate financial controls are in place and operating.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.10(216A,PL97-35) Designating eligible entities for unserved areas. If any geographic area of the state is not, or ceases to be, served by a community action agency and the governor decides to serve such area, the department will adhere to the requirements in Section 676A of the CSBG Act, U.S. Department of Health and Human Services statutory guidance, and other federal and state laws to solicit applications from qualified organizations.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.11(216A,PL97-35) Termination and reduction of funding. The department may terminate the designation of or reduce the share of CSBG funds allocated to an eligible entity if the department determines that an eligible entity fails to comply with the terms of an agreement, or the Iowa CSBG State Plan as amended to August 1, 2026, to provide CSBG services or to meet appropriate standards, goals, and other requirements established by the department, including performance objectives. If the department finds cause to terminate the designation of or reduce the funding of an eligible entity, the department will adhere to the requirements in Section 678C of the CSBG Act, U.S. Department of Health and Human Services statutory guidance, and other federal and state laws, including provisions of notification, technical assistance, corrective action, opportunity for a hearing under 441—Chapter 2506, and federal review, to initiate proceedings to terminate the designation of or reduce the funding of the eligible entity.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.12(216A,PL97-35) Client grievance and appeal process.

58.12(1) Eligible entities shall adopt client grievance procedures to address CSBG client complaints. The grievance procedures must be approved by the department. The procedures shall be used for all clients to file a complaint for nonappealable items. If complaints are unable to be resolved, the eligible entity shall forward the issue to the department for assistance with resolution.

58.12(2) The department will handle client appeals pursuant to 441—Chapter 2506. Items that are appealable are denial of eligibility, services, or benefits when services are solely CSBG-funded assistance or for services provided through co-funded programs where there is no other dispute resolution avenue.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

441—58.13(216A,PL97-35) Further criteria. The Iowa CSBG State Plan and Application as amended to August 1, 2026, and the Iowa CSBG Policies and Procedures Manual as amended to August 1, 2026, are incorporated by reference as part of these rules. If any rule in this chapter conflicts with federal law or rules, federal law or rules shall prevail.

[**ARC 0496D**, IAB 8/19/26, effective 10/1/26]

These rules are intended to implement Iowa Code chapter 216A and PL 97-35.

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CHAPTER 59
LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/31

441—59.1(216A,PL97-35,PL98-558) Definitions. For the purposes of this chapter, the following definitions apply:

"Assurance 16" means a provision of 42 U.S.C. Sections 8621 through 8630 as amended to August 1, 2026, that provides low-income home energy assistance program (LIHEAP) subrecipients the option of spending no more than 5 percent of their LIHEAP funds on services that encourage and enable households to reduce their home energy needs and thereby the need for energy assistance.

"DHHS" means the United States Department of Health and Human Services.

"Energy crisis" means weather-related (including natural disasters) supply shortage emergencies or other household energy-related emergencies as follows:

1. Nonworking heating unit (there must be a heating unit present).
2. Temporary need for alternate shelter due to lack of energy or fuel source.
3. Disconnected from utility service.
4. Past-due amounts owed create the risk of disconnection or an empty liquid propane (LP) or fuel oil (FO) tank.
5. LP tank 30 percent or less remaining.
6. Window or portable air-conditioning unit or repair of existing central air unit, when medically necessary.

"Household" includes all the people who occupy a housing unit (such as a house or apartment) as their usual place of residence. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit or a group of unrelated people sharing a housing unit, such as partners or roomers, is also counted as a household.

"LAA" means a local administering agency with which the department contracts to administer LIHEAP.

"Manual" or *"the manual"* means the LIHEAP Policy and Procedures Manual that is available on the department's website. All references herein are to those as amended to August 1, 2026.

"State plan" means the LIHEAP state plan that is available on the department's website. All references herein are to those as amended to August 1, 2026.

[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.2(216A,PL97-35,PL98-558) Household eligibility.

59.2(1) Households with incomes at or below the annually determined federal poverty guidelines, but not to exceed 150 percent of the guidelines, or an amount equal to 60 percent of the state median income for the state, according to DHHS, that are published annually in the Federal Register, may be eligible for assistance under LIHEAP. To receive benefits, an application must be made, eligibility must be determined, and program funds must be available before any payments may be made.

59.2(2) Proof of income eligibility is required as outlined in the manual. Any individual listed on a LIHEAP-approved application for the current fiscal year will not be listed on another application unless an exception is granted by the department.

59.2(3) Income criteria and guidelines are contained in the state plan and the manual.

59.2(4) All households applying for assistance under LIHEAP will simultaneously be making application for weatherization assistance, and 441—Chapter 63 will govern weatherization applications.

[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.3(216A,PL97-35,PL98-558) LAAs.

59.3(1) The department shall administer the LIHEAP program by contracting with LAAs that meet program and fiscal guidelines as required by federal law.

59.3(2) Each LAA will conduct outreach activities to ensure that eligible households are made aware of the program. In addition to its normal outreach functions, each LAA will authorize its workers to take

applications in an applicant's home and other locations specified in the manual. A notice of the appeal and hearing procedure pursuant to 441—Chapter 2506 must be posted at each intake site, and a copy of the appeal and hearing procedure and any other state-required handouts must be given to each client at the time of application or determination.
[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.4(216A,PL97-35,PL98-558) Application period. The application period for the program is between October 1, or the first working day of October, and April 30, or the last working day of April, or as defined in the manual.
[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.5(216A,PL97-35,PL98-558) Payments.

59.5(1) *Types of payments.* The following types of energy assistance payments may be made:

a. Payments may be made to suppliers on behalf of eligible households. The client's assistance shall remain as a credit on the client account until the program assistance is expended or the account is terminated.

b. Eligible households that pay an undesignated portion of the rent toward energy costs will receive assistance sent directly to the secondary vendor.

c. Direct payments may be made to eligible households as outlined in the manual.

59.5(2) *Duplicate and fraudulent payment control.* Each LAA is required to monitor, refer to the department, and prevent possible duplicate and other fraudulent applications and payments pursuant to the federal Office of Management and Budget guidance on the Payment Integrity Information Act of 2019 (PL 116-117) as amended to August 1, 2026, and the manual.
[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.6(216A,PL97-35,PL98-558) Change in status. The level of assistance for the program year will be determined based on the household's circumstances at the time of approval. If a household moves, a household of one passes away, or a household moves to a different service territory, etc., after applying for the program, the process outlined in the manual is to be followed.
[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.7(216A,PL97-35,PL98-558) Vendor agreement. A signed utility vendor agreement must be on file with the LAA before payments may be made to the vendor. If a fuel supplier does not sign a vendor agreement, a direct payment may be made to the eligible applicant. In cases where a vendor has not complied with all provisions of the vendor agreement, the state may approve direct payments to clients as an alternative.
[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.8(216A,PL97-35,PL98-558) Crisis assistance.

59.8(1) *Eligibility.* To be eligible for crisis assistance, a household must file an application, meet the income guidelines of LIHEAP, and meet the definition of "energy crisis."

59.8(2) *Evaluation.* Each crisis application will be evaluated individually by the LAA, which shall determine the appropriate resolution and the amount of assistance to be provided as defined by the manual.
[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.9(216A,PL97-35,PL98-558) Assurance 16 activities. LIHEAP customer services that encourage and enable households to reduce their home energy needs, and thereby reduce their need for energy assistance, shall be provided as Assurance 16 activities as outlined in the manual.
[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.10(216A,PL97-35,PL98-558) Grievances and appeals. Each LAA shall have a grievance process and procedures approved by the department for nonappealable actions. The following appeal and hearing procedures shall be used:

59.10(1) An applicant may initiate an appeal:

a. If an application is denied.

b. If an application is not acted upon within the required time frame.

c. If the benefit awarded is less than expected or less than previously notified.

d. If immediate or emergency support is refused or delayed beyond 48 hours or 18 hours for an energy crisis.

59.10(2) The department will process appeals pursuant to 441—Chapter 2506.

[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

441—59.11(216A,PL97-35,PL98-558) Further criteria. The state plan, the manual, and assistance award criteria for the program are incorporated by reference as part of these rules. If any rule in this chapter conflicts with federal law or rule, federal law or rule shall prevail.

[**ARC 0497D**, IAB 8/19/26, effective 10/1/26]

These rules are intended to implement Iowa Code chapter 216A, PL 97-35 and PL 98-558.

[Filed ARC 0497D (Notice ARC 0383D, IAB 6/24/26), IAB 8/19/26, effective 10/1/26]

CHAPTER 60
REFUGEE CASH ASSISTANCE

[Prior to 9/24/86 IAC Supp., see Refugee Service 715—Chapters 1 to 8]
[Prior to 2/11/87, Human Services[498]]

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

441—60.1(217) Alienage requirements.

60.1(1) *Immigration status.* A refugee is a person whose immigration status is one of the following statuses as issued by the United States Immigration and Naturalization Service:

a. Granted asylum under Section 208 of the Immigration and Nationality Act as amended to August 1, 2024.

b. Admitted as a refugee under Section 207 of the Act.

c. Paroled as a refugee or asylee under Section 212(d)(5) of the Act.

d. Cuban and Haitian entrants in accordance with requirements in 45 CFR Part 401 as amended to March 22, 2000.

e. Certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1988, as contained in Section 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 (Public Law 100-461 as amended to August 1, 2024).

f. Admitted for permanent residence, provided the individual previously held one of the statuses identified above.

60.1(2) *Nonrefugee child of refugee parents.* A nonrefugee child of refugee parents, when both parents in the home are refugees as defined in subrule 60.1(1), meets the alienage requirements. When only one parent is in the home and that parent is a refugee as defined in subrule 60.1(1), the child meets the alienage requirements.

60.1(3) *Immigration and Naturalization Service documents.* Each refugee shall provide Immigration and Naturalization Service documents in the form of either an I-94 card, an I-151 or I-551 card, an I-181 card, or other appropriate documentation to support the immigration status defined in subrule 60.1(1). If the name of the resettlement agency that resettled the refugee is not on the document, the refugee shall provide the name of the resettlement agency.

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.2(217) Application procedures. Application policies are defined in rules 441—40.23(239B), 441—40.24(239B), and 441—40.25(239B).

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.3(217) Effective date of grant. The date of eligibility for a grant is defined in rule 441—40.26(239B).

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.4(217) Accepting other assistance.

60.4(1) *Family investment program (FIP).* A refugee applicant or recipient shall accept a FIP grant if eligible under 441—Chapters 40 and 41.

60.4(2) *Supplemental security income (SSI).* Refugees who are 65 or older, blind, or disabled shall apply for and, if eligible, accept SSI.

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.5(217) Eligibility factors.

60.5(1) *Age.*

a. An unmarried refugee is considered an adult at age 18, except as defined in 441—subrule 41.21(1), and is eligible to receive refugee cash assistance if otherwise eligible.

b. Married refugees with or without children as defined in 441—subrule 41.21(1) are eligible regardless of age if other eligibility factors are met.

60.5(2) *Residency.* Residency requirements are defined in 441—subrule 41.23(1).

60.5(3) *Social security numbers.* Refugees are required to furnish a social security number as defined in 441—subrule 41.22(13).

60.5(4) *Determination of need.* Need will be determined as defined in 441—41.28(239B), except as otherwise provided in this chapter.

60.5(5) *Income.* Income is defined in rules 441—40.21(239B) and 441—41.27(239B).

60.5(6) *Resources.* Resource requirements are defined in rule 441—41.26(239B).

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.6(217) Students in institutions of higher education. A refugee who is a full-time student in an institution of higher education (other than a correspondence school) is ineligible for assistance with two exceptions:

1. The refugee is in a program approved as part of an individual employability plan as defined in subrule 60.9(3).
2. The refugee is in a program solely in English as a second language.

60.6(1) *Institution of higher education.* An institution of higher education is defined as an educational institution that provides an education program as specified below:

a. A public or private nonprofit institution of higher education is an educational institution that provides an educational program for which it awards an associate, baccalaureate, graduate, or professional degree; or at least a two-year program that is acceptable for full credit toward a baccalaureate degree; or at least a one-year training program that leads to a certificate or degree and prepares students for gainful employment in a recognized occupation.

b. A proprietary institution of higher education is an educational institution that provides at least a six-month program of training to prepare students for gainful employment in a recognized occupation.

c. A postsecondary vocational institution is a public or private nonprofit educational institution that provides at least a six-month program of training to prepare students for gainful employment in a recognized occupation.

60.6(2) *Full-time student.* A full-time student is a student who is carrying a full-time academic workload that equals or exceeds the following:

a. Twelve semester or 12 quarter hours per academic term in those institutions using standard semester, trimester, or quarter-hour systems.

b. Twenty-four semester hours or 36 quarter hours per academic year for institutions using credit hours to measure progress, but not using semester, trimester, or quarter systems, or the prorated equivalent for programs of less than one academic year.

c. Twenty-four clock hours per week for institutions using clock hours.

d. A series of courses or seminars that equals 12 semester hours or 12 quarter hours in a maximum of 18 weeks.

e. The work portion of a cooperative education program in that the amount of work performed is equivalent to the academic workload of a full-time student.

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.7(217) Time limit for eligibility.

60.7(1) *Assistance.* A refugee may receive assistance, if otherwise eligible:

a. For refugees who entered the country prior to October 1, 2021, during the first eight months the refugee is in the United States, beginning the month the refugee enters the country.

b. For refugees who entered the country on or after October 1, 2021, and for whom eligibility for refugee cash assistance was determined on or before May 4, 2025, during the first 12 months the refugee is in the United States, beginning the month the refugee enters the country.

c. For refugees who entered the country on or after October 1, 2021, and for whom eligibility for refugee cash assistance was determined on or after May 5, 2025, during the first four months the refugee is in the United States, beginning the month the refugee enters the country.

Exception: For asylees, the date of entry is the date asylum is granted. The 8-month, 12-month, or 4-month period of eligibility begins the month asylum is granted. A nonrefugee child in the home with a refugee parent (or refugee parents, if both are in the home) is eligible for assistance until the parent(s) has been in the United States for 8, 12, or 4 months, or until the child reaches 8, 12, or 4 months of age, whichever occurs first. For Afghan special immigrant (SI) parolees and Afghan SI conditional permanent residents (CPRs), the date is the date of "entry into the community," which is the date the individual departed a safe haven. For Afghan humanitarian parolees, the date is the latter of October 1, 2021, or the date of entry into the community, which is the date the individual departed a safe haven. "Safe haven" is the term the U.S. government and other relevant stakeholders have used for U.S. military bases in the continental United States that housed Afghans evacuated under Operation Allies Refuge/Operation Allies Welcome (OAR/OAW) as Afghans awaited resettlement to their ultimate state of residence.

60.7(2) *Resources.* The resources of refugees excluded because of the 8-month, 12-month, or 4-month limit will be considered in the same manner as though these refugees were included in the eligible group.

60.7(3) *Income.*

a. When the eligible refugee group has income, the income will be diverted to meet the needs of the refugees ineligible because of the time limit who would otherwise have been included in the refugee assistance group as defined in subrule 60.5(4).

b. The income of the refugees ineligible because of the time limit who would otherwise have been included in the assistance group as defined in subrule 60.5(4), will be used first to meet the needs of the ineligible group and then applied to the eligible group's needs.

c. The amount of need for the ineligible group is the difference between the needs of the group including the ineligible refugees and the needs of the group excluding the ineligible refugees. Any excess income will be applied to the needs of the eligible group.

d. Any cash grant received by the applicant under the Department of State or the Department of Justice reception and placement programs will be disregarded as income and as a resource.

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25; **ARC 9701C**, IAB 11/12/25, effective 1/1/26]

441—60.8(217) Criteria for exemption from registration for employment services, registration, and refusal to register. Each refugee applying for or receiving cash assistance shall register for employment unless the department determines the refugee is exempt because of reasons listed in subrule 60.8(1). Inability to communicate in English does not exempt a refugee from registration for employment services, participation in employability service programs and acceptance of appropriate offers of employment.

60.8(1) *Exemptions.* The following refugees are exempt from registration:

a. A refugee who is under the age of 16; or who is aged 16 but under the age of 18 and attending elementary, secondary, or vocational or technical school full-time; or a refugee who is enrolled full-time in training approved by the local office as part of an approved employability plan; or a refugee 18 years of age who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching the age of 19.

(1) A refugee will be considered as attending school full time when enrolled or accepted full time (as certified by the school or institute attended) in a school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) The refugee also will be considered in regular attendance in months when the refugee is not attending because of an official school or training program, vacation, illness, convalescence, or family emergency. A refugee meets the definition of regular school attendance until the refugee has been officially dropped from the school rolls.

(3) When the refugee's education is temporarily interrupted pending adjustment of the education or training program, assistance will be continued for a reasonable period of time to complete the adjustment.

b. A refugee aged 65 or older.

c. A refugee who is caring for another member of the household who has a physical or mental impairment that requires, as determined by a physician or licensed or certified psychologist and verified by the department, care in the home on a substantially continuous basis, and no other appropriate member of the household is available.

d. A woman who is pregnant if it has been medically verified that the child is expected to be born in the month in which registration would otherwise be required or within the next six months.

e. A parent or other caretaker relative of a child under the age of three who personally provides full-time care for the child with only very brief and infrequent absences from the child. Only one parent or other caretaker relative in a case may be exempt under this paragraph. "Brief and infrequent absence" means short-term absences that do not reoccur on a regular basis. Any involvement by the parent employed less than 129 hours per month or attending school less than full-time, as defined by the school, will be considered brief and infrequent. Recreational activities and vacations by the parent or child that result in the parent being absent from the child will be considered brief and infrequent.

f. A refugee who is working at least 30 hours a week in unsubsidized employment expected to last a minimum of 30 days. This exemption continues to apply if there is a temporary break in full-time employment expected to last no longer than ten workdays.

g. A refugee who is ill, when determined by the department on the basis of medical evidence or another sound basis that the illness or injury is serious enough to temporarily prevent entry into employment or training.

h. A refugee who is incapacitated, when determined by a physician or licensed or certified psychologist and verified by the department, that a physical or mental impairment, by itself or in conjunction with age, prevents the refugee from engaging in employment or training.

60.8(2) *Registration.* A refugee not exempt under subrule 60.8(1) will be considered an employable refugee. An employable refugee shall register with the department of workforce development and, within 30 days of receipt of aid, participate in the employment services provided by the bureau of refugee services. The department does permit, but does not mandate, the voluntary registration for employment services of any applicant or recipient of refugee cash assistance who is exempt under the provisions of this rule. If a voluntary registrant fails or refuses to participate in appropriate employability services, to carry out job search, or to accept an appropriate offer of employment, the bureau of refugee services may de-register the refugee for up to 90 days from the date of determination that failure or refusal has occurred, but the refugee's cash assistance will not be affected.

60.8(3) *Refusal to register.*

a. An employable applicant refugee who refuses or fails to cooperate in accepting a referral to the department of workforce development or the bureau of refugee services, refuses or fails to appear at the department of workforce development office for registration, or refuses or fails to mail or deliver the registration form to the bureau of refugee services, will be denied assistance.

b. Assistance for an employable recipient refugee will be terminated when the refugee refuses or fails to register with the department of workforce development or the bureau of refugee services.

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.9(217) Work and training requirements.

60.9(1) *Standards applicable to both work and training assignments.* The following standards must be met before an employable refugee can be required to accept a work or training assignment. A job offered, if determined appropriate under subrules 60.9(1) and 60.9(2), is required to be accepted by the refugee without regard to whether the job would interrupt a program of services planned or in progress unless the refugee is currently participating in a program in progress of on-the-job training or vocational training approved as part of an individual's employability plan or the refugee is enrolled full-time in a professional recertification program approved as part of an individual's employability plan.

a. The job or training referral must be related to the physical and mental capability of the person to perform the task on a regular basis. Any claim of adverse effect on physical or mental health will be based on adequate medical testimony from a physician or licensed or certified psychologist indicating that participation would impair the person's physical or mental health.

b. The total daily commuting time to and from home to the work or training site to which the person is referred shall not normally exceed two hours, not including the transporting of a child to and from a child care facility, unless a longer commuting distance and time is generally accepted in the community, in which case the round trip commuting time shall not exceed the generally accepted community standards.

c. The work or training site to which the person is referred must not be in violation of applicable federal, state, and local health and safety standards.

d. Referrals shall not be made that are discriminatory in terms of age, sex, race, creed, color, or national origin.

e. When child care is required, the child care must meet state licensing or registration requirements.

f. Available manpower statistics for a local area must indicate adequate employment potential for persons obtaining the given training. The employment must also meet the other appropriate work requirements.

g. The work or training assignment must be within the scope of the refugee's employability plan.

h. The quality of training must meet local employers' requirements so that the refugee will be in a competitive position within the local labor market. The training must also be likely to lead to employment that will meet the appropriate work criteria.

i. If a refugee is a professional in need of professional refresher training and other recertification services in order to qualify to practice the refugee's profession in the United States, the training may consist of full-time attendance in a college or professional training program, provided that the training is approved by the department as a part of the refugee's employability plan; it does not exceed one year's duration (including any time enrolled in the program in the United States prior to the refugee's application for assistance); it is specifically intended to assist the professional in becoming relicensed in the refugee's profession; and, if completed, it can realistically be expected to result in relicensing.

60.9(2) *Appropriate work requirements.* The local office, in making a determination of appropriate work, shall utilize the following criteria:

a. Appropriate work may be temporary, permanent, full-time, part-time, or seasonal work if it meets the other work standards defined in subrule 60.9(1).

b. The wage shall meet or exceed the federal or state minimum wage law, whichever is applicable, or if these laws are not applicable, the wage shall not be less favorable than the wage normally paid for similar work in that labor market but in no event shall it be less than three-fourths of the minimum wage rate.

c. The daily hours of work and the weekly hours of work shall not exceed those customary to the occupation.

d. No person shall be required to accept employment if:

(1) The position offered is vacant due to a strike, lockout, or other bona fide labor dispute.

(2) The person would be required to work for an employer contrary to the conditions of the person's existing membership in the union governing that occupation. However, employment not governed by the rules of a union in which the person has membership may be deemed appropriate.

60.9(3) *Development of an individual employability plan.* An individual employability plan will be developed as a part of a family self-sufficiency plan where applicable for each recipient of refugee cash assistance in a filing unit who is not exempt under subrule 60.8(1). The individual employability plan will:

a. Be designed to lead to the earliest possible employment and not be structured in such a way as to discourage or delay employment or job seeking.

b. Contain a definite employment goal, attainable in the shortest time period consistent with the employability of the refugee in relation to job openings in the area.

60.9(4) *Job search requirements.* The department will mandate job search for employable refugees where appropriate.

a. An employable recipient of refugee cash assistance shall carry out a job search program beginning at any time mandated by the bureau of refugee services. The bureau of refugee services will require the job search program to begin no later than six months after the refugee entered the United States or at the time the refugee is determined eligible for refugee cash assistance, if the refugee has completed at least six months in the United States at the time of the determination.

b. The job search program shall continue for at least eight consecutive weeks and shall meet requirements that the bureau of refugee services determines appropriate, including the amount of time to be devoted to employer contacts per week or the number of employer contacts mandated per week.

c. The department will determine and carry out the procedures it considers necessary to ensure that mandates for participation in job search are met.

60.9(5) *Failure or refusal to accept employability services or employment.*

a. Unless the refugee is exempt as described at rule 441—60.8(217), the department will terminate assistance when an employable recipient of refugee cash assistance has failed or refused to comply with any of the following requirements without good cause. The refugee shall:

(1) Register for employment with the department of workforce development and, within 30 days of receipt of cash assistance, participate in employment services provided by the bureau.

(2) Apply for or accept an offer of employment meeting the standards above.

(3) Carry out job search.

(4) Go to a job interview arranged by the department or its designee.

(5) Participate in an employability service program that is determined to be available and appropriate for that refugee.

(6) Not voluntarily quit a job.

(7) Participate in a social service or targeted assistance program that the department determines to be available and appropriate for that refugee.

b. In cases of proposed action to terminate, discontinue, suspend, or reduce assistance, the department will give timely and adequate notice, following the same procedures as those used in the family investment program. The written notice will include:

(1) An explanation of the reason for the action and the consequences of failure or refusal.

(2) Notice of the refugee's right to file an appeal with the department. The department will determine whether a hearing will be granted.

c. For the first refusal or failure the refugee will be sanctioned for three payment months. Subsequent refusals or failures will result in a six-payment month sanction for each refusal or failure.

d. If the sanctioned individual is the only member of the filing unit, the assistance will be terminated. If the filing unit includes other members, the department will not take into account the sanctioned individual's needs in determining the filing unit's need for assistance.

e. A conciliation period prior to the imposition of sanctions must be provided for in accordance with the following time limitations. The conciliation effort will begin as soon as possible, but no later than 10 days following the date of failure or refusal to participate, and may continue for a period not to exceed 30 days. Either the department or the recipient may terminate this period sooner when either believes that the dispute cannot be resolved by conciliation.

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.10(217) Uncategorized factors of eligibility.

60.10(1) *Duplication of assistance.* A refugee whose needs are included in a refugee cash assistance grant will not concurrently receive a grant under any other public assistance program administered by the department. Neither will a recipient concurrently receive a grant from a public assistance program in another state.

60.10(2) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive refugee cash assistance when the other party, obligated to provide the support, is able to fulfill that part of the contract.

60.10(3) *Participation in a strike.*

a. The spouse and children will be ineligible for assistance for any month in which the other spouse or parent is participating in a strike on the last day of the month.

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

c. Definitions of a strike and participating in a strike are defined in 441—paragraph 41.25(5)*"c."*

60.10(4) *Restrictions.* Restrictions found in 441—subrule 41.25(11) apply to benefits issued under this chapter.

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.11(217) Temporary absence from home. Temporary absence from home is defined in 441—subrule 41.23(3).

[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.12(217) Application. The application will be processed as defined in rule 441—40.22(239B).
[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.13(217) Continuing eligibility. Continuing eligibility will be determined as defined in rule 441—40.27(239B), except that refugee cash assistance will be substituted for the family investment program whenever it appears.
[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.14(217) Alternate payees. Alternate payees are defined in 441—Chapter 40, except that refugee cash assistance will be substituted for the family investment program whenever it appears.
[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.15(217) Payment. Payment will be issued as defined in 441—Chapter 45, except that refugee cash assistance will be substituted for the family investment program whenever it appears.
[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

441—60.16(217) Overpayment recovery. Recovery of overpayments will be determined as defined in 441—Chapter 46, except that refugee cash assistance will be substituted for the family investment program whenever it appears.
[**ARC 9278C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 217.6.

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CHAPTER 61
REFUGEE SERVICES PROGRAM

[Prior to 9/24/86 IAC Supp., see Refugee Service Center 715—Chapters 1 to 8]
[Prior to 2/11/87, Human Services[498]]

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

441—61.1(217) Definitions.

"Cash assistance" means the same as defined in 45 CFR 400 (June 7, 2022).

"Client" means refugees or others determined eligible for services funded under the refugee program.

"Family self-sufficiency plan" means a plan that addresses the employment-related service needs of the employable members in a family for the purpose of enabling the family to become self-supporting through the employment of one or more family members.

"Individual employability plan" means a written plan outlining an individual's vocational goal and the services to be provided to reach the goal.

"Iowa state refugee program plan" means the report that describes the state of Iowa's refugee program plan to meet the standards, goals, and priorities required under the Immigration and Nationality Act and developed by the department on the basis of a consultative process for the successful resettlement of refugees.

"Office of refugee resettlement" means the same as established in 8 U.S.C.A. §1521 (April 30, 1994).

"Refugee" means the same as defined in 8 U.S.C. §1101(a) INA 101 (a)(42) (January 5, 2023).

"Refugee unit" means either an individual refugee or two or more refugees representing an identifiable group, as determined by the department.

"Resettlement agency" means any business, organization or group of related persons having a current contract with the United States Department of State's Bureau of Population, Refugees, and Migration for the resettlement of refugees within the United States of America.

"Unaccompanied refugee minor" means the same as defined in 6 U.S.C.A. §279 (December 23, 2008).

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.2(217) Authority. The department has been given authority to administer the refugee program by Executive Order Number 21, signed by the governor December 24, 1985. United States Department of State and United States Department of Health and Human Services rules govern various program operations.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.3(217) Eligibility.

61.3(1) *Eligible immigration status.* Refugees eligible for services are those who have a status listed under 45 CFR §400.43 (June 7, 2022) or one of the following statuses:

a. Iraqi and Afghan Special Immigrants pursuant to Section 1244(g) of Div. A of PL 110-181 (August 1, 2024) (8 U.S.C. §1157 note) and Section 602(b)(8) of Div. F of PL 111-8 (August 1, 2024) (8 U.S.C. §1101 note).

b. Victims of a severe form of trafficking in persons per the Victims of Trafficking and Violence Protection Act of 2000, PL 106-386 (August 1, 2024) and 22 U.S.C. §7105(b) (1) (A) and (C) (August 1, 2024).

61.3(2) *Unaccompanied minors.* In addition to the unaccompanied minors in the categories listed under subrule 61.3(1), the following are eligible for the Office of Refugee Resettlement (ORR) Unaccompanied Refugee Minors Program:

a. Unaccompanied minor with special immigrant juvenile status under 8 U.S.C. §1101(a)(27)(J) (August 1, 2024) who was in the custody of the secretary of health and human services at the time the dependency order was granted for such child or was receiving services pursuant to Section 501(a) of the Refugee Education Assistance Act of 1980 (8 U.S.C. §1522 note (August 1, 2024)) at the time such dependency order was granted.

b. Unaccompanied minor who has been granted U status pursuant to Section 101(a)(15)(U) of the Immigration and Nationality Act (8 U.S.C. §1101(a)(15)(U) (August 1, 2024)).

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.4(217) Planning and coordinating the placement of refugees. Planning and coordinating the placement of refugees will be established in the bureau of refugee services state plan as required by the United States Department of State and United States Department of Health and Human Services.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.5(217) Services of the department available for refugees. All services provided to the refugee and family have self-sufficiency as the goal. Direct and contracted services may include:

61.5(1) *Job development.* These services involve working with employers in job development, placement, training, retention, and upgrading.

61.5(2) *Social adjustment.* These services include assessment and short-term counseling to persons or families in a perceived crisis, referral to appropriate resources, the making of arrangements for necessary services, home management services, transportation, translation and interpretation services, and case management services.

61.5(3) *Health-related services.* These services include information, referral to appropriate resources, assistance in scheduling appointments and obtaining services, and counseling to individuals or families to help them understand and identify their physical and mental health needs and maintain or improve their physical and mental health.

61.5(4) *Resettlement services.* These services involve securing and training sponsors, arranging for refugees to resettle in Iowa and providing case management, employment services, and social adjustment services.

As required under the resettlement contract with the United States Department of State, the department provides case management, employment services, and social adjustment services to the refugees it resettles during their first 90 days in Iowa.

61.5(5) *Any additional service.* These services, upon submission to and approval of the director of the office of refugee resettlement, include any additional service aimed at strengthening and supporting the ability of a refugee individual, family, or refugee community to achieve and maintain economic self-sufficiency, family stability, or community integration that has been demonstrated as effective and is not available from any other funding source.

61.5(6) *Translation and interpretation services.* These services provide interpreter service from English into the refugee languages or vice versa and assistance in translating written materials.

61.5(7) *Immigration services.* These services provide information and assistance to refugees in securing permanent resident alien status and family reunification.

61.5(8) *Adjustment of status.* These services provide guidance in obtaining permanent alien status and citizenship.

61.5(9) *Employability services.* A family self-sufficiency plan will be developed for anyone who receives employment-related services from the department. These services are specifically designed to assist refugees to obtain employment and to improve the employability of work skills of the individual and include job referral to, and job placement with, private employers. Specific employability services include:

a. Employment services, which include such activities as the development of a family self-sufficiency plan, individual employability plan, world-of-work and job orientation, job clubs, job workshops, job development, referral to job opportunities, job search, and job placement and follow-up.

b. Employability assessment services, which include such activities as aptitude and skills testing.

c. English language instruction, which includes referrals to programs that offer a curriculum that places an emphasis on English as it relates to obtaining and retaining a job and to programs that are provided in a concurrent, rather than sequential, time period with employment or with other employment-related services.

d. On-the-job training, which includes referrals to training that is provided at the employment site and is expected to result in full-time, permanent, unsubsidized employment with the employer who is providing the training.

e. Vocational training, which includes referrals to driver education and training when provided as part of an individual employability plan.

f. Skills recertification, which includes referrals to training that meets the criteria for appropriate training. If an individual is a professional in need of professional refresher training and other recertification services in order to qualify to practice the individual's profession in the United States, the training may consist of full-time attendance in a college or professional training program, provided that such training:

(1) Is approved as part of the individual's employability plan by the state agency, or its designee;

(2) Does not exceed one year's duration (including any time enrolled in such program in the United States prior to the refugee's application for assistance);

(3) Is specifically intended to assist the professional in becoming relicensed in the professional's profession; and

(4) If completed, can realistically be expected to result in such relicensing. This training may only be made available to individuals who are employed.

g. Child care, which includes referrals to child care necessary for participation in an employability service or for the acceptance or retention of employment.

h. Transportation when necessary for participation in an employability service or for the acceptance or retention of employment.

i. Translation and interpretation services when necessary in connection with employment or participation in an employability service.

j. Case management services for refugees who are considered employable and for recipients of public assistance who are considered employable, provided that the services are directed toward a refugee's attainment of employment as soon as possible after arrival in the United States.

k. Assistance in obtaining employment authorization documentations.

l. Referral to Iowa workforce development for provision of any or all of the above services.

61.5(10) *Outreach services.* These services include activities designed to familiarize refugees with available services, to explain the purpose of these services, and to facilitate access to these services.

61.5(11) *Referral.* These services enable referral of refugee clients to mainstream service systems.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.6(217) Provision of services.

61.6(1) *Priority of services.* Services are provided to refugees in the following order of priority, except in certain individual extreme circumstances:

a. Refugees who are receiving cash assistance.

b. Unemployed refugees who are not receiving cash assistance.

c. Employed refugees in need of services to retain employment or to attain economic independence.

d. All newly arriving refugees in the United States who apply for services during the five-year period from their date of arrival.

61.6(2) *Limitations on eligibility.* Services as described in rule 441—61.5(217) may be provided in the first 60 months of resettlement unless the Office of Refugee Resettlement grants an exception to the 60-month limit. Referral, interpretation, citizenship, and naturalization services may be provided to the extent feasible past 60 months of resettlement for refugees, except that refugees who are receiving employability services, as defined in subrule 61.5(11), as part of an employability plan, as of September 30, 1995, may continue to receive those services through September 30, 1996, or until the services are completed, whichever occurs first, regardless of their length of residence in the United States, pursuant to 45 CFR 400 (June 7, 2022). In any case, services will first be provided for those refugees who are in the first two years of resettlement and who are in need of assistance in securing self-sufficiency.

61.6(3) *Service requirements.*

a. Services provided will be refugee-specific services that are designed specifically to meet refugee needs, except that vocational or job skills training, on-the-job training, or English language training need not be refugee specific.

b. Services will be provided, to the maximum extent feasible, in a manner that is culturally and linguistically compatible with a refugee's language and cultural background.

c. Services will be provided, to the maximum extent feasible, in a manner that includes the use of bilingual or bicultural women on service agency staffs to ensure adequate service access by refugee women.

d. The department will use its social service grants primarily for employability services designed to enable refugees to obtain jobs within one year of becoming enrolled in services in order to achieve economic self-sufficiency as soon as possible.

e. Social services may continue to be provided after a refugee has entered a job to help the refugee retain employment or move to a better job.

f. Social service grant funds may not be used for long-term training programs such as vocational training that last for more than a year or educational programs that are not intended to lead to employment within a year.

g. In planning and providing services, the department will take into account those services that a resettlement agency is required to provide for a refugee whom it sponsors in order to ensure the provision of coordinated services to refugees that are not duplicative.

h. To avoid interference with refugee employment, English language instruction and vocational training must be provided to the fullest extent feasible outside normal working hours.

i. English language instruction must be provided in a concurrent, rather than sequential, time period with employment or with other employment-related services.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.7(217) Application for services. Any person will have an opportunity to apply for services by contacting the department or any of its affiliated offices either in person, by telephone, by fax, in writing, or by contacting any department staff members. The department will determine the eligibility of each person for services. Applicants for refugee cash assistance will automatically be considered as applicants for services. The department will ensure that refugee women have the same opportunities as refugee men to participate in all services, including job placement services.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.8(217) Adverse service actions.

61.8(1) *Denial.* Services will be denied when the department determines any of the following apply:

a. The client is not in need of the service.

b. The client is not legally eligible.

c. The service is not covered in the state refugee program plan.

d. There is another community resource available to provide the services or a similar service free of charge to the client that will meet the client's needs.

e. The service for which the client is eligible is currently not available.

f. Funding is not available to provide the service.

g. The client refuses to allow documentation of eligibility.

h. The services requested are those for which other resettlement agencies are contractually responsible.

i. The person requesting service has been in the United States more than 60 months and the services requested do not include referral, interpretation, citizenship, or naturalization services.

61.8(2) *Termination.* A service may be terminated when the department determines any of the following apply:

a. The need to attain the goals to which the service was directed has been achieved.

b. After repeated assessment, it is evident that the family or individual is unable to achieve or maintain goals set forth in the family self-sufficiency or individual employability plan.

c. After repeated efforts, it is evident that the client is unwilling to accept further service.

d. The service is no longer available in the Iowa state refugee program plan.

e. There is another community resource available to provide the services or a similar service free of charge to the client that will meet the client's needs.

f. Funding is not available to provide the service.

g. The person receiving service has been in the United States more than 60 months and the services the person is receiving do not include referral or interpretation services.

61.8(3) *Reduction.* A service may be reduced when the department determines any of the following apply:

a. Continued provision of service at its current level is not necessary. The department will determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal.

b. Another community resource is available to provide the same or similar service to the client, at no financial cost to the client, that will meet the client's need.

c. Funding is not available to continue the service at the current level. The client will be reassessed to determine the level of service to be provided.

61.8(4) *Notice of adverse action.* In case of an action to terminate, reduce, or deny services, the department will give timely or adequate notice to the person or persons affected pursuant to 441—Chapter 16.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.9(217) Client appeals. Decisions made by the department or its designee adversely affecting its clients may be appealed according to 441—Chapter 2506.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—61.10(217) Refugee resettlement moneys. Money that is made available to the refugee sponsor for financial assistance in resettling the refugee unit must be spent in accordance with financial requirements and approved expenditures of the department, United States Department of State, and the state of Iowa comptroller and must go toward the benefit of the refugee unit.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.11(217) Unaccompanied refugee minors program. The department administers the unaccompanied refugee minors program under 441—Chapters 156, 112 through 116, and 202 and by federal guidelines provided by the United States Department of Health and Human Services (August 1, 2024). In consultation with other resettlement agencies, the director of the ORR determines the number of unaccompanied minors to be resettled in Iowa pursuant to 45 CFR 400 (June 7, 2022). Resettlement agencies will not bring unaccompanied minors into Iowa without the authorization of the director.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

441—61.12(217) Targeted assistance grants. "Targeted assistance grants" means United States Department of Health and Human Services formula allocation funding granted to the department for assistance to counties where, because of factors such as unusually large refugee populations (including secondary migration), high refugee concentrations, and high use of public assistance by refugees, there exists and can be demonstrated a specific need for supplementation of available resources for services to refugees.

61.12(1) *Administration of targeted assistance grants.* The department will make 95 percent of the total award available to the designated county except when the designated county has agreed to let the department administer the targeted assistance grant in its stead.

61.12(2) *Eligibility for services under targeted assistance grants.* Services funded by targeted assistance grants are limited to refugees who reside in the designated county.

61.12(3) *Services and limitations for services funded by targeted assistance grants.* Rules of 441—Chapter 61 are applicable to services funded by targeted assistance grants, except for subrules 61.5(5) and 61.6(1).

61.12(4) *Priority of services.* Services funded by targeted assistance grants will be provided in the following order of priority, except in certain individual extreme circumstances:

(1) Cash assistance recipients, particularly long-term recipients.

(2) Unemployed refugees who are not receiving cash assistance.

(3) Employed refugees in need of services to retain employment or to attain economic independence.

[**ARC 9148C**, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement Iowa Code sections 217.6 and 217.41 and chapter 622A.

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CHAPTER 62
RENT REIMBURSEMENT

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—62.1(425) Eligible claimants. This rule is effective for rent reimbursement claims received by the department on or after January 1, 2023.

62.1(1) The rent reimbursement program is available to claimants who:

a. Were at least 23 years of age or a head of household on December 31 of the base year,

b. Were not or will not be claimed as a dependent on another person's federal or state income tax return for the base year in the case of a claimant who is not disabled or at least 65 years of age,

c. Did not have household income in excess of the indexed amount determined pursuant to Iowa Code section 425.23(4) during the base year,

d. Are domiciled in Iowa at the time the claim is filed or were at the time of the claimant's death, and occupied and rented the property during any part of the base year.

62.1(2) If a homestead is occupied by two or more eligible claimants, each person may file a claim based upon each person's income and each person's share of the rent paid.

62.1(3) The computed reimbursement shall be determined in accordance with the applicable schedule provided in Iowa Code section 425.23(1) as adjusted by the indexed amount determined in Iowa Code section 425.23(4).

This rule is intended to implement Iowa Code sections 425.16(2)*"b,"*425.17(2) and 425.23.

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.2(425) Dual claims.

62.2(1) A claimant changing homesteads during the base year who will make property tax payments during the fiscal year following the base year and who also made rent payments during the base year is entitled to receive both a property tax credit and rent reimbursement.

62.2(2) Claimants must file separate claim forms for the property tax credit and the rent reimbursement with the county treasurer and the department, respectively.

62.2(3) The claims are to be based on the actual property tax due and rent constituting property tax paid, with a combined maximum of $1,000 upon which the credit and reimbursement can be calculated.

EXAMPLE: $800 property tax due
$400 rent constituting property taxes paid

a. The claim form for calculating the property tax credit must reflect the entire $800 amount.

b. The claim form for calculating the rent reimbursement must reflect only the remaining $200 of the $1,000 maximum allowance.

c. The department will issue refund warrants for rent reimbursement claims. The county treasurer will apply the credit.

This rule is intended to implement Iowa Code section 425.24.

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.3(425) Multipurpose building.

62.3(1) A multipurpose building is a building that is used for other purposes in addition to being used for living accommodations. If a portion of a homestead property is utilized for business purposes, the property is considered to be a multipurpose building.

62.3(2) The portion of the property tax due or rent constituting property tax paid attributable to the homestead only is to be used in determining the allowable credit or reimbursement. This portion is to be calculated by determining the percentage of the homestead square footage to the square footage of the entire multipurpose structure. This percentage is then to be applied to the property tax due in the current fiscal year or rent constituting property tax paid for the base year.

This rule is intended to implement Iowa Code section 425.17(8).

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.4(425) Income.

62.4(1) Income includes the amount of in-kind assistance received by the claimant for housing expenses, such as federal rent subsidy payments made directly to the landlord on behalf of the claimant and energy assistance benefits received by the claimant from or through a public utility.

62.4(2) In determining income, net operating losses and net capital losses are not to be considered. If the comparison of gains and losses results in a net gain, such amount shall be considered income. If the comparison results in a net loss, the net loss shall be disregarded.

This rule is intended to implement Iowa Code section 425.17(7).

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.5(425) Simultaneous homesteads. A person who rents one property and also rents another property for a simultaneous period of time is limited to claiming rent reimbursement on the property that is considered the person's domicile.

This rule is intended to implement Iowa Code section 425.17(4).

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.6(425) Mobile, modular, and manufactured homes. Rent paid by an eligible claimant for occupancy of a mobile, modular, or manufactured home subject to the annual tax as provided in Iowa Code chapter 435 is subject to reimbursement regardless of how the home is taxed.

This rule is intended to implement Iowa Code section 425.17(4).

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.7(425) Totally disabled.

62.7(1) A claimant is considered totally disabled only if the physical or mental impairment or impairments are of such severity that the claimant is not only unable to do work previously performed but cannot, considering the claimant's age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the claimant lives, or whether a specific job vacancy exists, or whether the claimant would be hired if the claimant applied for work.

62.7(2) For purposes of this rule, a person shall not be considered unable to engage in substantial gainful employment unless the person has attained the age of 18 on or before December 31 of the base year.

This rule is intended to implement Iowa Code section 425.17(11).

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.8(425) Household. "Household" includes the claimant and the claimant's spouse if living with the claimant at any time during the base year. "Living with" does not include a temporary visit. Only one claimant per household is entitled to a reimbursement.

This rule is intended to implement Iowa Code sections 425.17(5) and 425.22.

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.9(425) Homestead. A person who owns a homestead but is confined to a care facility shall be considered as occupying the owned homestead, provided the person does not lease or otherwise receive profits from others for the use of the homestead. The person shall be eligible for a property tax credit but shall not be eligible for a rent reimbursement.

This rule is intended to implement Iowa Code section 425.17(4).

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.10(425) Gross rent/rent constituting property taxes paid. "Gross rent" means the total amount of rent paid for use of the homestead by the claimant.

This rule is intended to implement Iowa Code section 425.17(3).

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.11(425) Leased land. An individual who owns a dwelling located on land owned by another may claim a credit of property taxes due on the dwelling and a reimbursement of rental payments made for the use of the land if the land has been assessed for taxation.

This rule is intended to implement Iowa Code section 425.17(4).
[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.12(425) Property: taxable status. In order for a claimant to be eligible to file a rent reimbursement claim, the property upon which the claimant resided during the base year must have been in a taxable status during the base year. If the property was taxable for only part of the base year, the rent reimbursement must be prorated accordingly (OP.ST. BD. Tax Rev. 187). However, this restriction does not apply to property that became tax exempt on or after July 1, 1986, provided the claimant received a reimbursement of rent constituting property taxes paid on the property when it was in a taxable status and continues to reside in the same property.

This rule is intended to implement Iowa Code section 425.17(4).
[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.13(425) Income: spouse. The income of a spouse does not have to be reported on the claimant's return unless the spouse lived with the claimant at the property upon which rent reimbursement is claimed. If the spouse lived with the claimant for only a portion of the base year, only that portion of the spouse's income that was received while living with the claimant must be reported as income on the claimant's return. If the spouse is eligible to claim reimbursement, the spouse does not have to include any income that was reported on the other claimant's (spouse's) return.

This rule is intended to implement Iowa Code section 425.17(6).
[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.14(425) Common law marriage.

62.14(1) A common law marriage is a social relationship between two persons that meets all the necessary requisites of a marriage except that it was not solemnized, performed, or witnessed by an official authorized by law to perform marriages.

62.14(2) The necessary elements of a common law marriage are:

a. A present intent of both parties freely given to become married,

b. A public declaration by the parties or a holding out to the public that they are spouses,

c. Continuous cohabitation together as spouses (this means consummation of the marriage), and

d. Capability of both parties to enter into the marriage relationship.

62.14(3) No special time limit is necessary to establish a common law marriage.

This rule is intended to implement Iowa Code section 425.17.
[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.15(425) Audit of claim.

62.15(1) *Authority.* The department may investigate the eligibility of a claimant for rent reimbursement.

62.15(2) *Recomputed rent reimbursement claim.* If the department determines a computed rent reimbursement is in error, the department shall collect any overpayment from the claimant or reimburse the claimant for any underpayment. If a claimant fails to reimburse the department for an overpayment, the amount of overpayment shall be deducted from any future rent reimbursement to which the claimant is entitled.

This rule is intended to implement Iowa Code section 425.27.
[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.16(425) Extension of time for filing a claim. The granting of an extension of time for filing a claim for reimbursement does not extend the time within which or the dates on or by which eligibility requirements must be satisfied.

This rule is intended to implement Iowa Code section 425.20.
[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.17(425) Proration of claims. If the director or the director's designee determines that the amount of funding provided pursuant to Iowa Code section 425.39 will be insufficient to pay all rent

reimbursement claims filed, the director or the director's designee will estimate the percentage at which the claims will be paid and will prorate the payment of each rent reimbursement claim by the same estimated percentage.

This rule is intended to implement Iowa Code sections 25B.7 and 425.39.

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.18(425) Unreasonable hardship. In order to avoid any unreasonable hardship to a claimant, the director or the director's designee may review the facts and circumstances of the claim as set forth by the claimant. The director or the director's designee may investigate all factors related to the specific case as deemed appropriate by the director or the director's designee. If the director or the director's designee is satisfied that the claim qualifies as an undue hardship for the claimant, the claim will be approved by the director or the director's designee.

This rule is intended to implement Iowa Code section 425.37.

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25]

441—62.19(425) Appeal. Notice of adverse action taken by the department shall be issued in accordance with 441—Chapter 16, and the right to appeal shall be given in accordance with 441—Chapter 2506.

This rule is intended to implement Iowa Code chapter 17A.

[**ARC 9309C**, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

[Filed ARC 6557C (Notice ARC 6382C, IAB 6/29/22), IAB 10/5/22, effective 1/1/23]
[Filed ARC 9309C (Notice ARC 8525C, IAB 12/11/24), IAB 5/28/25, effective 8/1/25]
[Editorial change: IAC Supplement 6/10/26]

CHAPTER 63
WEATHERIZATION

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/31

441—63.1(216A,PL94-385,PL98-558) Eligible households.

63.1(1) A household includes all the people who occupy a housing unit (such as a house or apartment) as their usual place of residence. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit or a group of unrelated people sharing a housing unit, such as partners or roomers, is also counted as a household. A household occupying a dwelling unit is eligible for assistance under the weatherization assistance program if the household:

a. Has an annual income no higher than 200 percent of the federal poverty guidelines determined in accordance with criteria established by the Director of the Office of Management and Budget (OMB).

b. Is receiving supplemental security income (SSI) or family investment program (FIP) assistance, regardless of income.

63.1(2) Household eligibility, including income verification, will be determined in accordance with the application requirements for the low-income home energy assistance program (LIHEAP), the application for which is considered a joint application. Household eligibility and prioritization for weatherization services are established annually.

63.1(3) Both owner-occupied and renter-occupied dwellings may be weatherized. However, rental units occupied by low-income residents shall be weatherized, providing benefits accrue primarily to the low-income tenants, rents are not raised because of the weatherization, and no undue or excessive enhancement occurs to the value of the dwelling unit. Landlords of rental dwellings must agree to have their dwellings weatherized before assistance is provided.

63.1(4) Provision of all weatherization program services are contingent upon the availability of funds.

[**ARC 0498D**, IAB 8/19/26, effective 10/1/26]

441—63.2(216A,PL94-385,PL98-558) Local administering agencies (LAAs).

63.2(1) The department will administer the program by utilizing community action agencies (CAAs) or their approved subcontractors or other public or nonprofit entities that have shown the ability or have the capacity to undertake a timely and effective weatherization program. Program funds shall be used for the purchase and installation of weatherization materials, training and technical assistance, administration, and supportive services.

63.2(2) LAAs will be required to sign a contractual agreement that specifies required and allowable program activities, including U.S. Department of Energy regulations, special conditions, participant forms, program and fiscal reporting, and audit requirements.

[**ARC 0498D**, IAB 8/19/26, effective 10/1/26]

441—63.3(216A,PL94-385,PL98-558) Application period. Households may apply for weatherization assistance between October 1, or the first working day of October, and September 30, or the last working day of September, as defined in the annual Weatherization Assistance Program State Plan as amended to August 1, 2026.

[**ARC 0498D**, IAB 8/19/26, effective 10/1/26]

441—63.4(216A,PL94-385,PL98-558) Payments.

63.4(1) *Duplicate and fraudulent payment control.* Each LAA is required to provide a system to monitor and prevent possible duplicate and other fraudulent applications and payments. Duplication cross-checks shall be based on the unique client or vendor identifier.

63.4(2) *Referrals.* Each LAA is required to refer all suspected cases of fraud, including duplicate payments, overpayments, and fraudulent statements on applications, to the department for investigation.

[**ARC 0498D**, IAB 8/19/26, effective 10/1/26]

441—63.5(216A,PL94-385,PL98-558) Grievances and appeals.

63.5(1) Each LAA shall have grievance policies and procedures approved by the department for nonappealable items, including quality or extent of work performed.

63.5(2) Items that are appealable to the department pursuant to 441—Chapter 2506 are:

a. Services that have been denied for eligibility.

b. Weatherization work that is delayed or postponed for extenuating circumstances. The LAA must document the reasons for the delay of services and inform the client and the department.

c. Quality or completeness of work, if the LAA has exhausted its grievance process.

d. LAA contractors and subcontractors that have exhausted the grievance process.

[**ARC 0498D**, IAB 8/19/26, effective 10/1/26]

441—63.6(216A,PL94-385,PL98-558) Further criteria. The Weatherization Assistance Program State Plan as amended to August 1, 2026, and Weatherization Assistance Program Policy and Procedures Manual as amended to August 1, 2026, are incorporated by reference as part of these rules. If any rule in this chapter conflicts with federal law or rule, the federal law or rule shall prevail.

[**ARC 0498D**, IAB 8/19/26, effective 10/1/26]

These rules are intended to implement Iowa Code section 216A.99, PL 94-385 and PL 98-558.

[Filed ARC 0498D (Notice ARC 0384D, IAB 6/24/26), IAB 8/19/26, effective 10/1/26]

CHAPTER 64
INDIVIDUAL DEVELOPMENT ACCOUNT (IDA)

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/31

441—64.1(541A) Definitions. As used in these rules, unless the context otherwise requires:

"Account holder" means the same as defined in Iowa Code section 541A.1.

"Charitable contributor" means an individual, company or organization that makes a contribution through a nonprofit association described in Section 501(c)(3) of the Internal Revenue Code as amended to August 1, 2026, which association makes a deposit to an individual development account and which association is exempt from taxation under Section 501(a) of the Internal Revenue Code as amended to August 1, 2026.

"Federal poverty level" means the poverty income guidelines established annually for a calendar year and published in the Federal Register by the U.S. Department of Health and Human Services.

"Financial institution" means a financial institution, including but not limited to a bank, savings and loan, or credit union, approved by the department to accept individual development accounts.

"Household" means the adults who are related by blood, marriage or adoption or who are unrelated but have maintained a stable family relationship together over a period of time and the individuals who are under 18 years of age related to the above adults by marriage, blood or adoption who are living together. "Living together" refers to domicile as evidenced by the parties' intent to maintain a home for their family and does not include a temporary visit.

"Individual contributor" means the same as defined in Iowa Code section 541A.1.

"Individual development account" or *"IDA"* means an investment account that has the characteristics described in Iowa Code section 541A.2 and is operated by the operating organization.

"Individual development account state match fund" means the fund established in the state treasury under the authority of the department into which are deposited funds for payment to operating organizations for state match payments to individual investment accounts and administrative costs to implement the individual investment account program.

"Minor account holder" means an account holder who is younger than 18 years of age.

"Operating organization" means an entity selected by the department for involvement in operating individual development accounts directed to the eligible target population.

"Source of principal" means any of the following sources of a deposit:

1. Deposits made by the account holder.
2. Deposits of state match payments.
3. Deposits of individual development account moneys that are transferred from another individual development account holder. The moneys transferred from another individual development account will be considered to be a deposit of principal made by the account holder.
4. Deposits made on behalf of the account holder by an individual contributor or a charitable contributor.

[**ARC 0499D**, IAB 8/19/26, effective 10/1/26]

441—64.2(541A) Establishment of individual development accounts. An investment account qualifies as an IDA when it is established and operates in accordance with the following.

64.2(1) *Operating organization.* The investment account shall be established through an operating organization.

64.2(2) *Account.* The account shall be opened at a financial institution and kept in the name of an individual account holder.

64.2(3) *Deposits.* Deposits made to an IDA are also known as sources of principal and shall be made in any of the manners indicated in the definition of "source of principal" in rule 441—64.1(541A).

64.2(4) *Investment of funds.* The funds deposited in the IDA may be invested in any investment that the financial institution is authorized to offer to the public.

64.2(5) *Income.* The account earns income.

64.2(6) *Maximum deposits of principal.* The total of all sources of principal in an individual development account may not exceed $30,000.

[**ARC 0499D**, IAB 8/19/26, effective 10/1/26]

441—64.3(541A) Eligibility, state match payments, and state tax provisions.

64.3(1) *Eligibility based on countable household income level.* Eligibility will be based on the prospective account holder's household income for the calendar year preceding the calendar year in which the IDA will be opened. The household income shall not exceed 200 percent of the federal poverty level as published in the same year. If an account holder's household income exceeds 200 percent of the federal poverty level in any subsequent year following the year that the account holder established the account, the account will remain open, but the account holder will not be eligible to receive the state savings match payment for deposits made during the year following the year when the household income exceeds 200 percent of the federal poverty level. If the prospective account holder files an income tax return on a fiscal year basis, the household income must nonetheless be computed on a calendar year basis.

64.3(2) *Countable household income.*

a. The household's countable income shall be the Iowa net income as defined in Iowa Code section 422.7, with the following inclusions and exclusions:

(1) Inclusions to the extent not already included in Iowa net income are as follows:

1. Capital gains.
2. Alimony.
3. Child support money.
4. Cash public assistance and relief, except property tax relief under Iowa Code chapter 425, subchapter II.
5. The gross payment amount of any pension or annuity, including but not limited to railroad retirement benefits.
6. Military retirement and veterans' disability pensions.
7. Interest received from local, state or federal government securities.
8. Workers' compensation.
9. The gross amount of disability income or "loss of time" insurance.

(2) Exclusions are as follows:

1. Gifts from nongovernmental sources.
2. Surplus foods, including food assistance.
3. Payments received by an individual under the age of 18 under the federal Social Security Act.
4. Other in-kind relief supplied by a governmental agency.

b. Income shall not be reduced by either a net operating loss carryover or by a capital loss carryover.

64.3(3) *Determination of income status and eligibility.*

a. In lieu of calculating countable household income as provided in subrule 64.3(2) to determine income status and eligibility of an individual to hold an IDA, the operating organization may use evidence of an individual's enrollment in a program with income eligibility restrictions that are equal to or less than the maximum household income provided in subrule 64.3(1) as sufficient for determining the individual's eligibility to hold an IDA.

b. In order to determine the amount of countable household income of an individual seeking to open an IDA and to maintain household income records on an annual basis, the operating organization shall use any of the following methods or other methods deemed appropriate by the operating organization to obtain accurate income information:

(1) The operating organization shall ask both the individual who wishes to establish an IDA and other members of the individual's household who have filed federal or state income tax returns to furnish a copy of the returns with attached W-2 statements and to sign a release of information form permitting the operating organization to receive from the Iowa department of revenue summary information indicating the Iowa net income or to receive a copy of the state income tax return for the specific calendar year used to establish income eligibility to participate in the IDA program and for specified successive calendar years during which the IDA account is open. The operating organization shall protect the confidentiality of this information.

(2) If the individual and members of the individual's household have not filed federal or state income tax returns for the calendar year used to determine eligibility, the operating organization shall ask the individual to provide copies of available financial records of the household to determine the amount of countable income for the calendar year used to determine eligibility.

(3) The operating organization may also ask the individual seeking to hold an IDA to sign a release of information form allowing the operating organization to obtain individual and household income records held by agencies administering the programs referred to in paragraph 64.3(3)*"a."* The operating organization shall use this information to verify and maintain household income records of individuals seeking to hold an IDA, thereby facilitating the administration of the IDA program. The operating organization shall maintain the confidentiality of this information. Countable household income determinations shall include the amount of the cash assistance provided through the programs referred to in paragraph 64.3(3)*"a."*

(4) If the individual has minimal or no financial records and the operating organization determines that the totality of the individual's circumstances corroborates a credible explanation for the absence of said records, the operating organization may accept a written self-declaration from the individual as sufficient to document initial income eligibility to hold an IDA.

c. The operating organization shall obtain and maintain income information records from an account holder and all members of the account holder's family on a yearly basis to determine continued IDA eligibility.

64.3(4) *Exemption from income tax for income earned on assets in an IDA.* Income earned on principal in an IDA will be exempt from state income tax even if the account holder's household income is greater than 200 percent of the federal poverty level for the tax year.

64.3(5) *State match payments.* The operating organization shall determine the account holder's countable household income and account deposits on an annual basis for the purpose of computing the state match payment. The operating organization shall file with the department a claim for a state match payment on behalf of the account holder by April 30 of the year following the year in which the account holder made deposits into the IDA. The claim shall be filed on a form provided by the department. The department will make a payment of a savings match on a 1:1 ratio on amounts of up to $2,000 that an eligible account holder deposited in the account holder's account the previous year. The total state savings match for all years shall not exceed $2,000 for any IDA. Neither the moneys transferred to an IDA from another IDA nor the state match received by the account holder pursuant to this subrule will be considered an account holder deposit for purposes of determining a state match payment. The department or operating organization shall make the state match payment directly to the IDA in the manner deemed appropriate by the department.

64.3(6) *Tax implications.* IDAs shall be subject to rule 701—302.44(422,541A).

[**ARC 0499D**, IAB 8/19/26, effective 10/1/26]

441—64.4(541A) Requests for proposals—operation of IDAs.

64.4(1) *Issuance of requests for proposals.* The department may issue requests for proposals (RFPs) for operating organizations interested in operating an IDA program. The RFP will require the operating organization to provide information in its proposal regarding the financial institution that the operating organization will use for the proposed IDA program. The department will include such information in evaluating proposals submitted in response to the RFP.

64.4(2) *Review criteria used to evaluate and select proposals responding to the RFP.* The department will evaluate and select proposals submitted by operating organizations in response to the RFP based upon but not limited to the criteria as provided in the RFP.

64.4(3) *Other considerations and guidelines.* Other considerations and guidelines in implementing IDAs are:

a. The department shall have the authority to designate and limit the number of locations where IDA projects will be implemented, taking into account demographic characteristics and geographic considerations.

b. The department will require all IDA operating organizations and projects to comply with any federal individual development account program requirements for drawing federal funding.

c. The department and the operating organization shall enter into an agreement that specifies the responsibilities of both parties. The agreement will incorporate by reference the provisions of the RFP.

d. The operating organization shall maintain a clear and precise audit trail of all deposits and withdrawals of funds in IDAs. All withdrawals from an IDA shall require a signature of approval from the operating organization. Upon the termination of the agreement between the operating organization and the department or upon the discontinuance of the IDA program for any reason, the IDA accounts under the management of that operating organization shall terminate and the funds in the IDAs shall be distributed to the account holders unless the operating organization and a successor operating organization located in the same geographic area and operating an IDA program approved by the department enter into an agreement for the transfer of IDA accounts to the successor operating organization. The department shall have authority to review and approve in advance the agreement between the two operating organizations.

e. Upon the termination of an operating organization's relationship with the financial institution holding its IDA accounts, the operating organization managing the accounts shall enter into an agreement with a department-approved successor financial institution to hold the accounts and shall arrange for the transfer of the accounts to the new financial institution. The new agreement shall be subject to the department's review and advance approval.

f. If an account holder moves within the state to a location that is not served by the operating organization but is served by another operating organization with a department-approved IDA program, the original operating organization shall arrange for the transfer of the account to a financial institution that has an agreement with the operating organization in the new location. If there is no operating organization in the new location, the IDA account shall be closed, with funds in the account distributed to the account holder; alternatively, the operating organization and the account holder may jointly agree to maintain the account under the management of the existing operating organization and financial institution. The operating organization shall provide a written notification to the department of all transfers of IDA accounts to the management of a new operating organization.

[**ARC 0499D**, IAB 8/19/26, effective 10/1/26]

441—64.5(541A) Authorized withdrawals of principal and income.

64.5(1) *Approved purposes for withdrawal of funds from an IDA.* An account holder may withdraw principal and income earned on principal from an IDA only with the written approval of the operating organization and only for the purposes outlined in Iowa Code section 541A.2(4).

64.5(2) *Conditions on withdrawals of principal and income.* An account holder may withdraw funds from the account holder's IDA subject to the following conditions:

a. Any amount of principal and income earned on principal, provided the sum is authorized under Iowa Code section 541A.2(4) and in accordance with the procedure for authorized withdrawals set forth under subrule 64.5(3).

b. If the account holder is 59½ years of age or older, any amount of principal and income earned on principal. Such withdrawals shall not require the approval of the operating organization.

64.5(3) *Procedures for account holder deposits and withdrawals.* The operating organization and the financial institution shall agree upon and provide to account holders procedures to facilitate authorized withdrawals.

[**ARC 0499D**, IAB 8/19/26, effective 10/1/26]

441—64.6(541A) Notice of nonapproved withdrawals and closure of the account.

64.6(1) *Nonapproved withdrawals and attempted withdrawals for nonapproved purposes.* The financial institution shall notify the operating organization within five calendar days of any withdrawals or attempted withdrawals that appear to be nonapproved. The financial institution shall refuse to release any funds that do not have the written authorization of approval from the operating organization.

64.6(2) *Closure of an IDA by the operating organization.* The operating organization may close an IDA pursuant to Iowa Code section 541A.2(6).

[**ARC 0499D**, IAB 8/19/26, effective 10/1/26]

441—64.7(541A) Transfers of assets of an IDA.

64.7(1) *Transfers by an adult account holder.* An adult account holder may transfer all or part of the assets in the adult account holder's IDA to any other account holder's IDA. Upon compliance by the operating organization and financial institution with the requirements of rule 441—64.5(541A), IDA account holders who have transferred funds into another individual's IDA account and any beneficiaries of the transferee's IDA account shall sign a waiver of liability form releasing the operating organization and the financial institution from civil liability and responsibility for the wrongful withdrawals of funds by the account holder due to the account holder's false representation of the purpose of the withdrawal, resulting in the loss to the account balance of deposited principal funds, including individual and charitable contributions, transferred funds, and the state match payments.

64.7(2) *No transfers of assets from a minor account holder's IDA.* Neither a minor account holder nor the parents or legal guardian of such minor account holder shall have the right or ability to transfer assets from the minor account holder's IDA to the IDA of any other account holder.

64.7(3) *Transfers when an account holder dies.* At the time an IDA is established, an account holder shall name a contingent beneficiary or contingent beneficiaries or an account holder transferee to whom the assets of the account holder's IDA shall be transferred upon the account holder's death. Upon the account holder's death, the account assets shall be transferred to the named contingent beneficiary or contingent beneficiaries or to the account holder transferee's IDA, as applicable. A named contingent beneficiary or contingent beneficiaries or account holder transferee may be changed at the discretion of the account holder. If the named contingent beneficiary or contingent beneficiaries or account holder transferee is deceased or otherwise does not accept the transfer, the assets of the deceased account holder's IDA shall be transferred to the IDA state match fund.

[**ARC 0499D**, IAB 8/19/26, effective 10/1/26]

These rules are intended to implement Iowa Code chapter 541A.

[Filed ARC 0499D (Notice ARC 0379D, IAB 6/24/26), IAB 8/19/26, effective 10/1/26]

TITLE VII
FOOD PROGRAMS

CHAPTER 65
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM ADMINISTRATION

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

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—65.1(234) Definitions.

"Notice of expiration" means a message printed on a form prescribed by the department, which is automatically issued to the household.

"Supplemental Nutrition Assistance Program" or *"SNAP"* means benefits provided by the federal program administered through 7 CFR Parts 270 through 283 (May 2, 2022).

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.2(234) Administration of program. SNAP will be administered in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq. (August 1, 2024); 7 CFR Parts 270 through 283 (May 2, 2022); PL 99-603 (August 1, 2024); PL 104-193 (August 1, 2024); PL 107-171 (August 1, 2024); and with 42 U.S.C. Chapter 7 (January 7, 2011). A copy of the federal law and regulations may be obtained at no more than the actual cost of reproduction by contacting the department.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.3(234) State options. The state of Iowa has selected SNAP state options that are tailored to meet the state's operational considerations and policy preferences. These options can be viewed on the U.S Department of Agriculture website under the State Options Report.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.4(234) Treatment centers and group living arrangements. Substance use treatment or rehabilitation centers and group living arrangements shall provide a list of participating residents to the department on a monthly basis.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.5(234) Appeals. Fair hearings and appeals are provided according to 441—Chapter 2506.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

441—65.6(234) Proration of benefits. Benefits will be prorated using a 30-day month.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.7(234) Notice of expiration issuance. Issuance of the automated Notice of Expiration will occur with the mailing of a form prescribed by the department.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.8(234) Verification. Persons whose applications meet the initial criteria for error-prone cases may be subject to special verification procedures, including a face-to-face interview and additional documentation requirements in accordance with 481—Chapter 72.

Failure to cooperate with the investigations division of the department of inspections, appeals, and licensing in establishing eligibility factors will not result in denial or cancellation of the household's SNAP benefits. The investigations division will gather as much information as possible without the client's cooperation. If further information is needed based on those findings, a request for information must be sent to the household.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.9(234) Prospective budgeting.

65.9(1) *Weekly or biweekly income.* The department will convert income and deductions that occur on a weekly or biweekly basis to monthly figures using family investment program (FIP) procedures.

65.9(2) *Income averaging.* The department will average income by anticipating income fluctuations over the certification period. The number of months used to arrive at the average income should be the number of months that are representative of the anticipated income fluctuation.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.10(234) Effective date of change. A SNAP change caused by, or related to, a public assistance grant change will have the same effective date as the public assistance change.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.11(234) Work requirements. As a condition of eligibility for SNAP benefits, each nonexempt household member must comply with SNAP work requirements.

65.11(1) *Deregistration.* Work registrants who obtain employment or otherwise become exempt from the work requirement subsequent to registration or who are no longer certified for participation are no longer considered registered.

65.11(2) *Employment and training (E&T) program.* The department will design and operate an employment and training program with the purpose of providing SNAP participants opportunities to gain skills, training, work, or experience that will increase their ability to obtain regular employment and meet state or local workforce needs in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq. (August 1, 2024).

a. The employment and training program serves individuals who are:

(1) SNAP recipients or SNAP applicants.

(2) Not receiving FIP assistance or other cash assistance under Title IV, such as Tribal Temporary Assistance for Needy Families (TANF) or Refugee Cash Assistance.

(3) Physically and mentally able to work or will be able to work within the next one year.

b. The department or its designee shall serve as the provider of employment and training services for SNAP recipients who wish to volunteer, except for those who are also recipients of FIP benefits. Federal law prohibits FIP recipients from participating in any SNAP E&T program.

c. The program offers a range of services from basic skills to advanced occupational training in order to accommodate persons with various levels of need and abilities. The department or its designee may require a potential E&T participant to engage in aptitude or vocational testing activities when deemed necessary to determine if a component is appropriate for improving employability.

d. The E&T program will be designed in consultation with the state workforce development board or with private employers or employer organizations if the department determines the latter approach is more effective and efficient.

(1) The E&T program will be designed to include case management services and at least one or more or a combination of employment and training components.

(2) An E&T plan will be submitted to the Food and Nutrition Service (FNS) of the U.S. Department of Agriculture annually, in accordance with 7 CFR 273.7(c)(6) (May 2, 2022), and will be amended as necessary within the required time frame prior to implementation.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.12(234) Income. In determining eligibility, the department will exclude educational income, including any educational loans on which payment is deferred, grants, scholarships, fellowships, veterans' educational benefits, and the like excluded under Title XIX of the Social Security Act (42 U.S.C. Section 1396 2011 et seq. (August 1, 2024)) for the state's modified adjusted gross income (MAGI)-related medical assistance program, subject to subrule 65.12(4).

65.12(1) Notwithstanding anything to the contrary in these rules or regulations, the department will exclude educational income based on amounts earmarked by the institution, school, program, or other grantor as made available for the specific costs of tuition, mandatory fees, books, supplies, transportation, and miscellaneous personal expenses (other than living expenses).

65.12(2) If the institution, school, program, or other grantor does not earmark amounts made available for the allowable costs involved, students will receive an exclusion from educational income for educational assistance verified by the student as used for the allowable costs involved. Students can also verify the allowable costs involved when amounts earmarked are less than amounts that would be excluded by a strict earmarking policy.

65.12(3) For the purpose of this rule, mandatory fees include the rental or purchase of equipment, materials and supplies related to the course of study involved.

65.12(4) Certain types of student income will be treated as follows, regardless of how they are considered for MAGI-related medical assistance.

a. Wages are not excluded.

b. Federally funded work study is excluded.

c. State-funded work study is excluded up to the amount earmarked for educational expenses.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.13(234) Deductions. A household in which all members are homeless may choose the homeless standard deduction in place of the shelter and utility expenses deduction.

65.13(1) Households choosing this option are not required to verify shelter-related expenses.

65.13(2) Households choosing this option are not eligible to receive a shelter or utility deduction.

65.13(3) The amount of the homeless standard deduction is determined by the FNS and adjusted annually.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.14(234) Student resources. Any income excluded by rule 441—65.12(234) will be excluded from resources.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

441—65.15(234) Reinstatement. When assistance has been canceled for failure to provide requested information, assistance will be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date all information required to establish eligibility is provided.

[**ARC 9310C**, IAB 5/28/25, effective 8/1/25]

These rules are intended to implement Iowa Code sections 234.12 and 234.6.

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◊ Two or more ARCs

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

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

CHAPTER 66
EMERGENCY FOOD ASSISTANCE PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—66.1(234) Definitions.

"Household" means a single individual living alone or a group of related or nonrelated individuals who live together, who are not boarders or residents of an institution, and who purchase and prepare food for home consumption.

"TEFAP" means The Emergency Food Assistance Program as authorized by the Emergency Food Assistance Act of 1983 as amended through PL 107-249, enacted October 23, 2002.

[**ARC 9311C**, IAB 5/28/25, effective 8/1/25]

441—66.2(234) Household eligibility. Household eligibility is determined by residence, household size, and income.

66.2(1) *Residence.* Household members must be residing in the state of Iowa.

66.2(2) *Household size.* Household size is determined by the number of people living in a dwelling, excluding boarders, as household is defined in rule 441—66.1(234).

66.2(3) *Income eligibility.* All earned and unearned income of the household must be considered in determining eligibility.

a. Income defined. Income means all income received by an individual from sources identified by the U.S. Census Bureau in computing median income and includes:

(1) Money wages or salary;
(2) Net income from nonfarm self-employment;
(3) Net income from farm self-employment;
(4) Dividends;
(5) Interest;
(6) Income from estates or trusts;
(7) Net rental income and royalties;
(8) Public assistance or welfare payments;
(9) Pensions and annuities;
(10) Workers' compensation;
(11) Alimony;
(12) Child support;
(13) Veterans' pensions;
(14) Social security;
(15) Railroad retirement;
(16) Supplemental security income;
(17) State or federal assistance;
(18) Veterans' benefits;
(19) Black lung benefits;
(20) All disability pensions;
(21) State supplementary assistance;
(22) Unemployment compensation benefits; and
(23) Income from minors under 16 years of age.

b. Determination of income. Earned or unearned income is the gross annual, monthly, or weekly income.

(1) Biweekly income is to be multiplied by 2.15 to determine monthly income.
(2) Adjusted gross self-employment income will be averaged over a 12-month period.
(3) Income received from interest and dividends will be averaged over a 12-month period.
(4) The amount of income that stops or starts during the month will be estimated based on the best information available.

c. Income exclusions. When calculating total household income for this program, all income must be excluded that is specifically excluded for food assistance by federal statute, especially those sources listed in federal regulations at 7 CFR 273.9(c)(10) as amended to May 2, 2022.

d. Income guidelines. Households are eligible for TEFAP when the countable household income is at or below 185 percent of the federal poverty guidelines. These federal guidelines are revised annually, effective every July 1.

[**ARC 9311C**, IAB 5/28/25, effective 8/1/25]

These rules are intended to implement Iowa Code sections 234.6 and 234.12.

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CHAPTER 67
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

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

441—67.1(135) Definitions. Definitions can be found in 7 CFR Part 246 (as amended to August 1, 2024) and state-specific definitions can be found in Iowa WIC policies and procedures. Iowa WIC policies and procedures describe the manner in which the department implements and operates all aspects of program administration within its jurisdiction in accordance with 7 CFR Part 246 (as amended to August 1, 2024), United States Department of Agriculture (USDA) policy memorandums, USDA guidance documents, and any other documents issued by USDA to implement the WIC program.
[**ARC 9149C**, IAB 4/30/25, effective 7/1/25]

441—67.2(135) Administration of program. The department implements the WIC program by following guidance from 7 CFR Part 246 (as amended to August 1, 2024), USDA policy memos, USDA guidance documents, and any other documents issued by USDA to implement the WIC program.
[**ARC 9149C**, IAB 4/30/25, effective 7/1/25]

441—67.3(135) Certification of participants. Eligibility will be determined pursuant to 7 CFR Section 246.7 (as amended to August 1, 2024), any USDA-issued documents used to implement the WIC program, and the WIC Policy and Procedure Manual (as amended to August 1, 2024).
[**ARC 9149C**, IAB 4/30/25, effective 7/1/25]

441—67.4(135) Food delivery.

67.4(1) *Responsibilities of department—approving or denying applications.* The department will determine if applications meet mandatory specifications and may deny an application pursuant to 7 CFR Part 246 (as amended to August 1, 2024); USDA federal regulations; USDA guidance documents; or the Iowa WIC Program Vendor Guidance (as amended to August 1, 2024), Iowa WIC Program Vendor Application (as amended to August 1, 2024), and Iowa WIC Program Vendor Handbook and Agreement (as amended to August 1, 2024).

67.4(2) *Responsibilities of WIC vendors.*

a. A potential vendor shall make application to the department's WIC program and shall accept the obligations imposed by the signing of the Iowa WIC Program Vendor Agreement and Handbook (as amended to August 1, 2024) prior to acceptance of any WIC food instrument. To qualify as a WIC vendor, the vendor shall meet all of the criteria outlined in the Iowa WIC Program Vendor Guidance (as amended to August 1, 2024), Iowa WIC Program Vendor Application (as amended to August 1, 2024), and Iowa WIC Program Vendor Agreement and Handbook (as amended to August 1, 2024).

b. The vendor must agree to adhere to all provisions of the Iowa WIC Program Vendor Application (as amended to August 1, 2024), Iowa WIC Program Vendor Agreement and Handbook (as amended to August 1, 2024), and Iowa WIC Program Vendor Guidance (as amended to August 1, 2024).

67.4(3) *Criteria for approving products for inclusion in the WIC food package.*

a. A product shall meet the federal regulations governing the WIC food package.

b. If a vendor offers specialty eggs for retail sale, the vendor shall maintain an inventory of conventional eggs for retail sale sufficient to meet federal and state requirements for participation in the WIC program.

c. Products will be evaluated for use in the Iowa WIC program based on nutrient content, packaging, container size, labeling, availability to wholesale distributors, cost, and participant preference. The state reserves the right to limit the number of foods, infant formulas, exempt infant formulas, and WIC-eligible nutritionals for the WIC-approved food list based on accessibility, availability, retail value of product, USDA recommendations, increased number of WIC participants, changes in appropriation of funds and administrative efficiency.

d. The approved food list provides more specifics on what is allowed or not allowed for each of the WIC-approved foods.

e. In addition to the criteria specified above, the department reserves the right to make changes to the criteria or further restrict the number and types of brands of any products in order to contain the cost of the food package through competitive procurement of rebate contracts or other similar means.

f. The department reserves the right to discontinue specific brand names and products if the cost is administratively burdensome for that particular product.

g. The department reserves the right to add or delete products pursuant to federal regulations.

[**ARC 9149C**, IAB 4/30/25, effective 7/1/25]

441—67.5(135) Education.

67.5(1) Participants who are high risk, as defined in the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024) shall be seen by a licensed dietitian as described in the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024) with a care plan developed as described in the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).

67.5(2) To the extent that time and resources are available, nutrition education may be provided to applicants who are not eligible to receive other WIC services.

[**ARC 9149C**, IAB 4/30/25, effective 7/1/25]

441—67.6(135) Right to appeal—participant. Fair hearings and appeals for participants are provided pursuant to 441—Chapter 2506 and 7 CFR Section 246.9 (as amended to August 1, 2024).

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441—67.7(135) Right to appeal—local agencies. Fair hearings and appeals for local agencies are provided pursuant to 441—Chapter 2506, 7 CFR Section 246.18 (as amended to August 1, 2024), and 7 CFR Section 246.24 (as amended to August 1, 2024).

[**ARC 9149C**, IAB 4/30/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—67.8(135) Right to appeal—vendor. Fair hearings and appeals for vendors are provided pursuant to 441—Chapter 2506, 7 CFR Section 246.12 (as amended to August 1, 2024), and 7 CFR Section 246.18 (as amended to August 1, 2024).

[**ARC 9149C**, IAB 4/30/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—67.9(135) State monitoring of contract agencies. At minimum, one of the persons from the department responsible for reviewing a contract agency shall be a licensed dietitian.

[**ARC 9149C**, IAB 4/30/25, effective 7/1/25]

441—67.10(135) Civil rights. The Iowa WIC program shall operate in compliance with state and federal regulations and FNS Instruction 113-1 (as amended to August 1, 2024) to ensure the rights of all individuals under the WIC program.

[**ARC 9149C**, IAB 4/30/25, effective 7/1/25]

441—67.11(135) WIC program violation. Participants or vendors are subject to the sanctions outlined below if determined by contract agency or department staff to be guilty of abusing the WIC program or its regulations.

67.11(1) *Participant violation.* Violations may be reported by contract agency staff, vendors, the public, FNS staff, or department staff. All suspected cases of fraud will be investigated by the department. All sanctions will be administered by the department. Contract agencies will be notified of any actions taken against WIC participants by the department.

a. Whenever possible, the participant is contacted via telephone concerning the violation. Documentation is maintained according to procedures set forth in the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).

b. Participants who violate WIC program regulations are subject to sanction in accordance with the schedule below:

Violation	Sanction Action
1. Intentional false statement(s) or misrepresentation of income, name, residence, family size (including receiving and using benefits for children no longer in the family), medical data, pregnancy, and/or date of birth to obtain WIC benefits.	One-year disqualification and pay full restitution
2. Return of WIC benefits to vendor for unapproved food items, nonfood items, credit or cash (attempted or actual). Claim amount less than $100. Buy, trade, exchange, transfer, sell, or offer to buy, trade, exchange, transfer, sell, or allow any other person to buy, trade, exchange, transfer, sell or offer to buy, trade, exchange, transfer or sell eWIC card/benefits for unapproved food items, nonfood items, cash or favors. Claim amount less than $100.	Two-month disqualification and pay full restitution Subsequent violation of any claim amount: one-year disqualification and pay full restitution
3. Return of WIC benefits to vendor for unapproved food items, nonfood items, credit or cash (attempted or actual). Claim amount greater than $100. Buy, trade, exchange, transfer, sell, or offer to buy, trade, exchange, transfer, sell or allow any other person to buy, trade, exchange, transfer, sell or offer to buy, trade, exchange, transfer, or sell WIC foods for unapproved food items, nonfood items, cash or favors. Claim amount greater than $100.	One-year disqualification and pay full restitution
4. Creating a public nuisance or disrupting normal activities through verbal misconduct or physical disruptions at the local WIC agency, farmers market, or vendor location.	First violation: Education/counseling Second subsequent violation: Warning letter Third subsequent violation: Two-month disqualification Fourth subsequent violation: Any subsequent violation(s) will result in a one-year disqualification.
5. Verbal abuse or harassment of WIC staff, vendors, farmers market vendors and/or other WIC participants. This includes verbal abuse or harassment in person, on social media, or over the telephone.	Two-month disqualification Subsequent violation will result in a one-year disqualification.
6. Physical abuse (directly or indirectly carrying out the actual harm or threatening to do harm) of WIC staff, vendors, vendor staff, farmers market vendors, farmers market vendor staff, and/or other WIC participants.	Any violation will result in a one-year disqualification.
7. Destruction of property, theft of eWIC card(s) or theft from a local WIC agency, vendor, vendor staff, farmers market vendor, farmers market vendor staff, and/or another WIC participant.	Any violation will result in a one-year disqualification.
8. Collusion with staff to improperly obtain benefits.	One-year disqualification and pay full restitution
9. Dual participation resulting from intentional misrepresentation.	One-year disqualification and pay full restitution

Violation	Sanction Action
10. Trafficking WIC food benefits, WIC benefits, or WIC items and/or collusion with an authorized vendor.	One-year disqualification and pay full restitution
11. Other violations of this chapter or the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).	As appropriate per this chapter or the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).

c. Local law enforcement may be notified in appropriate cases.

d. Fifteen days' notice must be given prior to all disqualifications. In all cases, the participant must be informed of the reason for the disqualification, of the right to appeal the decision through the fair hearing process, and of eligibility to receive WIC services at the end of the disqualification period.

e. A disqualification may apply to all members of a family who are on the WIC program.

f. Violations are cumulative. However, a participant will not have sanctions assessed for committing a second violation when the second violation occurs before the participant receives notice of the first violation and the second violation is the same as the first. A participant who commits the same violation a second time following receipt of a notice for the first violation is subject to a one-year disqualification.

g. When a participant improperly received benefits as a result of intentionally making a false or misleading statement(s) or intentionally misrepresenting, concealing, or withholding facts or sells or attempts to sell benefits the participant received from the WIC program and is disqualified from the WIC program, the participant may be required to make restitution of the cash value of the improperly received or used WIC benefits. The department may establish a claim against the participant for the full value of the improperly received benefits.

(1) The department will issue a written notice of restitution and disqualification.

(2) If the participant chooses a repayment plan for claims, the department will assist in developing a payment schedule. If the participant has not paid the department directly within 30 days of the notice of restitution and disqualification, the department will pursue collection of the dollar amount owed and benefits will be discontinued until the claim is paid.

h. The department may decide not to impose a mandatory disqualification pursuant to 7 CFR Section 246.12(u)(2) (as amended to August 1, 2024). All decisions are at the discretion of the department.

i. When a disqualification period has ended, the individual disqualified may be reinstated if the individual's certification period is still current. If the individual's certification period is not current, the individual will need to complete a certification appointment.

j. The department will maintain a master list of all participant violation notices, disqualifications, and statements of restitution. The participant's notice of violation must also indicate when it is a second offense.

67.11(2) *Vendor violations.* There are five types of sanctions that are applied to vendors for violations of WIC program regulations: nonpayment of food instruments, issuance of violation points, temporary disqualification, permanent disqualification, and civil money penalties (CMPs).

a. Nonpayment of food instruments. If the vendor has been terminated from the WIC program and submits a claim, it will be fully denied.

b. Administrative and procedural violation points. Administrative and procedural violations are offenses to the provisions of the Iowa WIC Vendor Agreement and Handbook (as amended to August 1, 2024) that do not rise to the level of fraud against the WIC program or its participants.

(1) These violations are an indication of a vendor's inattention to or disregard of the requirements of the WIC vendor agreement. It is in the department's interest to record and consider these violations when considering whether to continue its contractual relationship with the vendor.

(2) One or more transactions prior to notification of the vendor constitute only one violation if they contain the same error.

(3) The assignment of violation points does not limit the department's right to effect stronger penalties and sanctions in cases in which there is evidence of an intentional or systematic practice of abusing or defrauding the Iowa WIC program.

Violation	Points Per Event
1. Developing and using promotional materials including stickers, tags, labels, or channel strips with the WIC service mark to identify WIC-approved foods.	5
2. Developing and using vendor-created WIC vendor identification decals to indicate vendor is an authorized vendor.	5
3. Failure to allow WIC participants to leave the vendor with WIC foods that were debited/removed from their eWIC account during a WIC transaction.	5
4. Failure to post eWIC signs in the cash register lane that has a working WIC terminal if the vendor is not integrated.	5
5. Failure to provide vendor ECR system participant receipts to WIC participants during each WIC transaction.	5
6. Failure to reimburse department for potentially overpaid food instrument or provide reasonable explanation for the cost of the food instrument.	10
7. Refusal to accept valid WIC food instruments from participants.	10
8. Discriminatory treatment of WIC participants, such as requiring WIC participants to use special checkout lanes or provide extra identification, or disallowing the use of coupons or other vendor discounts in WIC transactions that are allowed in non-WIC transactions.	10
9. Treating WIC customers differently by offering them incentive items, vendor discounts, coupons, or other promotions that are not offered to non-WIC customers.	10
10. Providing to WIC participants incentive items not prior authorized by the department.	10
11. Failure to carry out corrective action plan developed as a result of monitoring visit.	10
12. Accepting the return of food purchased with WIC food instruments for cash or credit toward other purchases.	10
13. Issuing “rain checks” or credit in exchange for WIC food instruments.	10
14. Stocking out-of-date, stale, or moldy WIC foods.	10
15. Failure to submit vendor price assessment reports as requested.	10
16. Failure to train all employees and ensure their knowledge regarding WIC program procedures set forth in the vendor’s current agreement and in the current publication of the Iowa WIC program’s vendor instruction booklet.	10
17. Requiring WIC participants to purchase a particular brand when other WIC-approved brands are available.	10
18. Not allowing WIC participants to use discount coupons or promotional specials to reduce the WIC food instrument amount.	10
19. Requiring to enter the PIN for the participant and/or asking for the participant’s PIN.	10
20. For vendors that have special WIC prices, failure to post WIC prices on the shelf or on the package.	15
21. Contacting WIC participants in an attempt to recover funds not paid by WIC.	15
22. Providing false information on the price assessment report.	15
23. Knowingly entering false information or altering information on the eWIC receipt/benefits.	10
24. Requiring other cash purchases to redeem WIC food instruments.	15
25. Failure to obtain infant and/or special needs formula from an approved source listed by the Iowa WIC program.	15
26. Offering incentive items with a value of more than $1.99.	15

Violation	Points Per Event
27. Scanning any UPC code that is not affixed to the actual item being purchased by the WIC participant.	20
28. Failure to allow purchase of up to the full amount of WIC foods authorized on the food instrument if such foods are available and desired by the WIC participant.	20
29. Failure to maintain minimum stocking requirements.	10
30. Other violations of this chapter or the Iowa WIC Program Vendor Agreement and Handbook or the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).	As appropriate per this chapter, the Iowa WIC Program Vendor Agreement and Handout or the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024)

c. One-year disqualification. With an administrative finding of the following patterns of sanctions, the vendor will be disqualified for one year:

(1) A pattern of allowing purchase of nonapproved food items in exchange for WIC food instruments or for foods provided in excess of those listed on the WIC food instrument (federally mandated sanction).

(2) Accumulation of 45 or more violations points within a single federal fiscal year of the agreement period (department sanction).

(3) Failure to provide access to vendor premises or in any manner to hinder, impede or misinform authorized WIC personnel in the act of conducting an on-site education, monitoring or investigation visit (department sanction).

(4) Loss of department of inspections, appeals, and licensing license (department sanction).

(5) Submitting for payment a WIC food instrument redeemed by another authorized vendor (department sanction).

(6) Threatening or verbally abusing WIC participants or authorized WIC program personnel in the conduct of legitimate WIC program transactions (department sanction).

(7) Submitting for payment WIC food instruments known by the vendor to have been lost or stolen (department sanction).

(8) Participating with other individuals, including but not limited to WIC employees, vendors, and participants, in systematic efforts to submit false claims for reimbursement of improper WIC food instrument (department sanction).

d. A vendor will be disqualified from being a WIC vendor for three years with an administrative finding of any violation detailed in 7 CFR Section 246.12(l)(iii) (as amended to August 1, 2024).

e. A vendor will be disqualified from being a WIC vendor for six years pursuant to 7 CFR Section 246.12(l)(1)(ii) (as amended to August 1, 2024).

f. The department will impose mandatory vendor sanctions pursuant to 7 CFR Section 246.12(l)(1)(i) (as amended to August 1, 2024).

g. The following does not have a point value but shall result in or extend a disqualification period:

For each month in which a vendor accepts WIC food instruments during a disqualification period, the disqualification period shall be extended by 30 days.

h. The above sanctions notwithstanding, the state of Iowa reserves the right to seek civil and criminal prosecution of WIC vendors for any and all instances of dealing in stolen or lost food instruments, trading cash and other inappropriate commodities for food instruments, or cases in which there exists evidence of a clear business practice to improperly obtain WIC funds or other practices meeting the definition of fraud as defined in 7 CFR Part 246 (as amended to August 1, 2024) or the Iowa Code.

i. A vendor shall not be entitled to receive any compensation for revenues lost as a result of any temporary or permanent disqualification.

j. A minimum of 15 days' notice is provided prior to all disqualifications, except for permanent disqualifications assessed under paragraph 73.19(2)*"f,"* which are effective on the date of receipt of

the notice of administrative action. When the department determines that an offense has occurred, a disqualification letter with supporting documentation is prepared for the WIC director's signature. The disqualification letter identifies the specific offenses that the vendor is charged with and the procedures for filing an appeal. Voluntary withdrawal from the Iowa WIC Program Vendor Agreement and Handbook to avoid a sanction is not allowed.

k. The department is responsible for issuing all warning and disqualification letters. Contract agencies are informed of all vendor correspondence regarding violations. In situations where participant violations are also involved, the contract agency is responsible for follow-up, as detailed in subrule 73.19(1).

l. Disqualification from the WIC program may result in disqualification as a retailer in SNAP pursuant to 7 CFR Section 246.12(h)(3)(xxvi) (as amended to August 1, 2024), 7 CFR Section 246.18(b)(1) (as amended to August 1, 2024), and 7 CFR Section 246.12(l)(1)(xi) (as amended to August 1, 2024).

m. The department will disqualify a vendor who has been disqualified from SNAP pursuant to 7 CFR Section 246.12(l)(1)(vii) (as amended to August 1, 2024) and 7 CFR Section 246.12(l)(1)(ix) (as amended to August 1, 2024).

n. CMPs.

(1) When the department determines that a CMP shall be imposed in lieu of disqualification for reasons specified under paragraph 73.19(2)*"f"* or *"m,"* it shall use the civil money penalty formula in accordance with 7 CFR Section 246.12(k)(1)(x) (as amended to August 1, 2024) to determine the CMP.

(2) If a vendor does not pay, only partially pays, or fails to timely pay a CMP, the department will disqualify the vendor for the length of the disqualification corresponding to the violation for which the CMP was assessed. "Failure to timely pay a CMP" includes the failure to pay a CMP in accordance with an installment plan approved by the department.

(3) Money received by the state WIC agency as a result of CMPs or fines assessed against a vendor and any interest charged in the collection of these penalties and fines shall be considered as WIC program income.

[**ARC 9149C**, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement 42 U.S.C. Section 1786 and Iowa Code section 234.6(1).

[Filed ARC 9149C (Notice ARC 8537C, IAB 12/11/24), IAB 4/30/25, effective 7/1/25]

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

CHAPTERS 68 to 70
Reserved

CHAPTER 71
EMERGENCY FOOD DISTRIBUTION PROGRAM
Rescinded, effective 11/1/86

CHAPTER 72
EMERGENCY FOOD AND SHELTER PROGRAM
Rescinded, effective 11/1/86

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 73
MANAGED CARE

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

441—73.1(249A) Definitions.

"Appeal" means a review by an MCO or PAHP of an adverse benefit determination as specified in 42 CFR 438.400(b).

"Capitation payment" means a monthly payment to the MCP on behalf of each enrollee for the provision of health or dental services under the contract. Payment is made regardless of whether the enrollee receives services during the month.

"Choice counseling" means the provision of unbiased information on MCPs or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the MCPs or the state, to answer questions about each of the options available, and to facilitate enrollment with an MCP.

"Claim" means a formal request for payment for benefits received or services rendered.

"Clean claim" means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. "Clean claim" does not include a claim from a provider that is under investigation for fraud or abuse or a claim under review for medical necessity.

"CMS" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"Code of Federal Regulations" or *"CFR"* means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government, and all references herein are as amended to July 1, 2026.

"Community-based case management" means a collaborative process of planning, facilitation, and advocacy for options and services to meet an enrollee's needs through communication and available resources to promote high-quality, cost-effective outcomes.

"Contract" means a contract between the department and an MCP. These contracts shall meet all applicable requirements of state and federal law, including the requirements of 42 CFR 434.

"Covered services" means physical health, behavioral health, dental, and long-term care services set forth in rule 441—73.5(249A).

"Discharge planning" means the process, which begins at admission, of determining a continued need for treatment services and of developing a plan to address ongoing needs.

"Electronic visit verification system" or *"EVV system"* means an electronic system that providers can check into at the beginning of and check out of at the end of each period of service delivery to monitor enrollees' receipt of care.

"Emergency medical condition" means the same as defined in 42 CFR 438.114(a).

"Emergency services" means the same as defined in 42 CFR 438.114(a).

"Enrollee" means a hawki, IHAWP, dental wellness plan or Medicaid member who is eligible for MCP enrollment and has been enrolled with an MCP as described in subrule 73.3(2).

"Enrollment broker" means the entity the department uses to enroll persons in an MCP. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law, including 42 CFR 438.10.

"Hawki program" means the healthy and well kids in Iowa program as set forth in 441—Chapter 86, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act as amended to July 1, 2026.

"HIPP" means the health insurance premium payment program.

"Home- and community-based services" or *"HCBS"* means services that are provided as an alternative to long-term care institutional services in a nursing facility or an intermediate care facility for persons with an intellectual disability (ICF/ID) or to delay or prevent placement in a nursing facility or ICF/ID.

"Incident reporting" means the reporting of critical events or incidents deemed sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to:

1. Abuse and neglect;
2. The unauthorized use of restraint, seclusion or restrictive interventions;
3. Serious injuries that require medical intervention or result in hospitalization, or both;
4. Criminal victimization;
5. Death;
6. Financial exploitation;
7. Medication errors; and
8. Other incidents or events that involve harm or risk of harm to a participant.

"Iowa health and wellness plan" or *"IHAWP"* means the medical assistance program set forth in 441—Chapter 74.

"Level of care" refers to the amount, type, and intensity of medical care services required to meet an individual's health and safety needs.

"Long-term care" or *"LTC"* means the services of a nursing facility (NF); an ICF/ID; the Woodward state resource center; or services funded through Section 1915(c) HCBS waivers, the Section 1915(i) habilitation program, and the PACE program outlined in 441—Chapter 88.

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

"Managed care plan" or *"MCP"* refers to MCOs and PAHPs. The benefits provided through managed care will be paid for by the MCP participating in the programs pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the MCP, consistent with this chapter and with the contract between the department and the MCP.

"Mandatory enrollment" means mandatory participation in a managed care plan as specified in subrule 73.3(2).

"Medical loss ratio" means the percentage of capitation payments that is used to pay medical or dental expenses.

"Medically necessary services" means those covered services that are under the terms and conditions of the contract and 42 CFR 438.54(b)(2).

"Member" means any person determined by the department to be eligible for the Medicaid program, hawki program, IHAWP, or dental wellness plan.

"Money Follows the Person (MFP) Rebalancing Demonstration Grant" means a federal grant that will assist Iowa in transitioning individuals from an NF or ICF/ID into the community and in rebalancing long-term care expenditures.

"Needs-based eligibility" means an evaluation to determine and establish an individual's need for habilitation services.

"Network" or *"provider network"* means a group of participating health or dental care providers (both individual and group practitioners) linked through contractual arrangements to the MCP to supply a range of health or dental care services.

"Out-of-network provider" means any provider that is not directly or indirectly employed by or does not have a provider agreement with the MCP or any of its subcontractors pursuant to the contract between the department and the MCP.

"Participating providers" means the providers of covered physical health, behavioral health, dental, and long-term care services that have contracted with a managed care plan.

"Passive enrollment process" means the process by which the department assigns a member to a managed care plan and that, in accordance with 42 CFR 438.54, seeks to preserve existing provider-member relationships and relationships with providers that have traditionally served Medicaid members, if

possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available managed care plans.

"Prepaid ambulatory health plan" or *"PAHP"* has the meaning set forth in 42 CFR 438.2.

"Prior authorization" means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.2(249A) Contracts with a managed care plan (MCP).

73.2(1) The department may enter into a contract with an MCP licensed under the provisions of insurance division rules set forth in 191—Chapter 40 for the scope of services as described in rule 441—73.6(249A).

73.2(2) The department will determine that the MCP meets the following requirements:

a. The MCP shall make available services to enrollees as established in the contract.

b. The MCP shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the MCP's debts if the MCP becomes insolvent. The MCP shall comply with the insurance division of the Iowa department of insurance and financial services provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

c. The MCP shall attain and maintain accreditation by the National Committee for Quality Assurance (NCQA) or URAC.

73.2(3) If not already accredited, the MCP must demonstrate it has initiated the accreditation process as of the contract effective date and must achieve accreditation at the earliest date allowed by NCQA or URAC. Prior to the contract effective date, the MCP must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with 191—Chapter 40.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.3(249A) Enrollment.

73.3(1) *Enrollment area.* The coverage area for enrollment shall be statewide.

73.3(2) *Members subject to enrollment.* All hawki program, IHAWP, and dental wellness plan members shall be subject to mandatory enrollment in an MCP. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in an MCP:

a. Members who are medically needy as described in rule 441—75.8(249A).

b. Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements pursuant to 441—Chapter 75.

c. Persons who are currently presumptively eligible as defined in 441—Chapter 75.

d. Persons eligible for PACE who voluntarily elect PACE coverage as described in 441—Chapter 88.

e. Persons enrolled in HIPP pursuant to 441—Chapter 75.

f. Persons eligible only for the Medicare savings program as described in 441—Chapters 75 and 76.

g. American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.

h. Persons who have a Medicaid eligibility period that is retroactive as described in 441—Chapter 76.

i. Persons who are inmates of a public institution and ineligible for Medicaid benefits as described in 441—Chapter 75.

j. Persons residing in the Iowa veterans home as described in 801—Chapter 10.

73.3(3) *Enrollment process.* The department will notify members who must be enrolled in an MCP of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438.54.

a. General. Members may receive MCP choice counseling from the enrollment broker. The enrollment broker will provide information about individual MCP benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

b. *Auto-assignment.* Effective no earlier than the first day of the month of the member's application to Medicaid, the member will be assigned to an MCP using the department's auto-enrollment process and offered the opportunity to choose from the available MCPs within a time frame specified in the auto-assignment letter.

c. *Request to change enrollment.* An enrollee may, within 90 days of initial enrollment, request to change enrollment from one MCP and enroll in another MCP. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Enrollment changes are effective no later than the first day of the second month beginning after the date on which the enrollment broker receives the enrollee's written or verbal request.

d. *Ongoing enrollment.* Enrollees shall remain enrolled with the chosen MCP for a total of 12 months.

e. *Enrollment cycle.* Prior to the end of the enrollee's annual enrollment period, the enrollee will be notified of the option to maintain enrollment with the current MCP or to enroll with a different MCP.

73.3(4) *Benefit reimbursement prior to enrollment.*

a. Prior to the effective date of MCP enrollment, except as provided in paragraph 73.3(4)*"b,"* the department will reimburse providers for covered program benefits pursuant to 441—Chapters 74 through 91, as applicable for eligible members.

b. The MCP shall be responsible for covering newly retroactive Medicaid eligibility periods prior to the effective date of enrollment for babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.4(249A) Disenrollment process.

73.4(1) *Enrollee-requested disenrollment.* An enrollee may request disenrollment with an MCP as follows:

a. During the first 90 days following the date of the enrollee's initial enrollment with the MCP, the enrollee may request disenrollment, for any reason, in writing or by a telephone call to the enrollment broker's toll-free member telephone line.

b. After the 90 days following the date of the enrollee's enrollment with the MCP, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the MCP's grievance system. If the member does not experience resolution, the MCP shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

(1) The MCP does not, because of moral or religious objections, cover the service the member seeks.

(2) The member needs related services to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

(3) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health or dental care needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

c. The final decision for disenrollment will be determined by the department.

73.4(2) *Disenrollment by department.* Disenrollment will occur when:

a. The contract between the department and the MCP is terminated.

b. The enrollee becomes ineligible for Medicaid, the hawki program, IHAWP, or the dental wellness plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the MCP will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care plan enrollment.

d. The department has determined that participation in HIPP as described in 441—Chapter 75 is more cost-effective than enrollment in managed health care.

e. The enrollee dies.

f. The enrollee has changed residence to another state.

73.4(3) *Managed care plan-requested disenrollment.* An MCP shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health or dental care needs or change in health or dental care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs. The only exception is when the MCP can document and provide conclusive evidence to the department that the enrollee's continued enrollment seriously impairs the MCP's ability to furnish services to either this particular enrollee or other enrollees. The MCP shall have a multi-level verification process by which the department is assured that disenrollment is not requested for another reason.

73.4(4) *Disenrollment effective date.*

a. The effective date of a department-approved disenrollment will be no later than the first day of the second calendar month beginning after the month in which:

(1) The enrollee requests disenrollment;

(2) The department notifies the enrollee and MCP of disenrollment; or

(3) The MCP requests disenrollment.

b. The enrollee shall remain enrolled in the MCP and the MCP will be responsible for services covered under the contract until the effective date of disenrollment unless the enrollee is in an inpatient setting at the time of disenrollment. If the enrollee is in an inpatient setting at the time of disenrollment, the MCO shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.5(249A) MCP covered services.

73.5(1) *Required services—MCOs.* An MCO shall provide:

a. For all enrolled members, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

(1) Area education agency services.

(2) Dental services not provided in an outpatient hospital setting.

(3) Infant and toddler program services.

(4) Local education agency services.

(5) State of Iowa veterans home services.

(6) Money Follows the Person (MFP) Rebalancing Demonstration Grant-funded services.

b. For IHAWP enrolled members, services as set forth in 441—Chapter 74.

c. For hawki enrolled members, services as set forth in 441—Chapter 86.

73.5(2) *Community-based case management service.* The MCO is required to provide services that meet requirements specified in the contract.

73.5(3) *Value-added services.* An MCP may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

73.5(4) *Required services—PAHPs.* A PAHP shall provide services to enrollees under the contract with the department and on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates. PAHPs shall provide:

a. For enrollees other than IHAWP enrollees and hawki program enrollees, services as set forth in 441—Chapters 73, 74, 78, and 88, with the exception of the following:

(1) Area education agency services.

(2) Inpatient hospital or institutional services.

(3) Advance directive requirements in dental nonclinical services, such as transportation.

(4) Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, the Woodward state resource center, or ICFs/ID).

(5) Inpatient psychiatric care provided at the state-administered mental health institutes.

(6) Services provided at specialized adolescent psychiatric facilities.

(7) Day treatment and partial hospitalization services for persons aged 20 or under.

(8) Enhanced services provided to certain eligible recipients.

b. For IHAWP enrolled members, services as set forth in 441—Chapter 74.

c. For hawki enrolled members, services as set forth in 441—Chapter 86.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.6(249A) Amount, duration and scope of services.

73.6(1) The MCP shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the department. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3), the MCP shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The MCP shall not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, as a condition of payment, the MCO shall provide prior authorization for any admissions to an NF, an ICF/ID, a psychiatric medical institution for children (PMIC), and a state-administered mental health institute. Prior MCO approval is also required for all out-of-state placements.

73.6(2) The MCP may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract. The MCP shall not:

a. Avoid costs for services covered in the contract by referring members to publicly supported health or dental care resources.

b. Deny reimbursement of covered services based on the presence of a preexisting condition.

73.6(3) The MCP shall allow each enrollee to choose a health or dental professional, to the extent possible and appropriate, within the MCP's provider network. The MCP shall ensure compliance with the Americans with Disabilities Act (ADA) as amended to July 1, 2026, in the delivery and approval of all services.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.7(249A) Emergency services.

73.7(1) Emergency services shall be available 24 hours a day, seven days a week.

73.7(2) In accordance with federal funding requirements, including 42 CFR 438.114, the MCP shall:

a. Cover emergency services without the need for prior authorization and shall not limit reimbursement to network providers.

b. Cover and pay for emergency services regardless of whether the provider that furnishes the services is enrolled with Iowa Medicaid or has a contract with the MCP.

c. Pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

d. Cover the medical screening examination provided to a member who presents to an emergency department with an emergency medical condition. This requirement applies to MCOs only.

73.7(3) The MCP shall not deny payment for:

a. Treatment obtained when an enrollee has an emergency medical condition.

b. Treatment obtained when a representative of the MCP instructs the enrollee to seek emergency medical services.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.8(249A) Access to service.

73.8(1) The MCP shall ensure enrollees have access to services as specified in the contract. The MCP shall provide available, accessible, and adequate numbers of institutional facilities, service locations, and service sites and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hours-a-day, seven-days-a-week basis. At a minimum, access to services shall comply with the standards described in the contract. For areas of the state where provider availability is insufficient to meet these standards, for example, in health or dental professional shortage areas and medically underserved areas, the access standards shall meet the usual and customary standards for the community. Exceptions to the requirements contained in this rule shall be justified and documented to the state on the basis of community standards. All other services not specified in this rule shall meet the usual and customary standards for the community.

73.8(2) Choice of providers. An enrollee shall use the MCP's provider network unless the MCP has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance with federal funding requirements, including 42 CFR 431.51(b)(2), the MCO shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers that are not in the MCP network.

73.8(3) Continuity of care. The MCP shall have policies and procedures that provide for the continuity of care of treatment to ensure that a new enrollee's existing services are honored as required in the contract.

73.8(4) Adequate service referral support and after-hours call-in coverage. The MCP shall ensure enrollee access to service information and medical coverage 24 hours a day, 7 days a week, 365 days a year.

a. Member helpline. The MCP shall maintain a dedicated toll-free enrollee services helpline as established in the contract to handle a variety of member inquiries and to provide warm transfer of enrollees to outside entities, such as provider offices, and to internal MCP departments, such as care coordinators.

b. Nurse call line. The MCO shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, seven days a week from trained medical professionals.

73.8(5) The MCP shall ensure that network providers are responsible for providing preventive and primary health or dental care to the enrollee. Primary care providers shall initiate referrals for specialist care, where appropriate, and maintain the continuity of patient care. Primary care providers may be physicians, advanced registered nurse practitioners, or physician associates, licensed and practicing in accordance with state law.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.9(249A) Incident reporting.

73.9(1) The MCO shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting incidents for Section 1915(c) HCBS waivers; for the Section 1915(i) habilitation program; and as required for licensure of programs through the department of inspections, appeals, and licensing.

73.9(2) The MCO shall develop and implement policies and procedures, subject to department review and approval, to:

a. Address and respond to incidents;

b. Report incidents to the appropriate entities in accordance with required time frames; and

c. Track and analyze incidents.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.10(249A) Discharge planning. The MCO shall establish policies and procedures, subject to approval by the department, that protect an enrollee from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The MCO shall facilitate a seamless transition whenever an enrollee transitions between facilities or residences.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.11(249A) Level of care (LOC) assessment.

73.11(1) The department will retain full authority to determine whether the Medicaid LOC or needs-based assessment has been completed in a timely manner by the appointed vendor. The MCO will be notified once an enrolled member's LOC determination has been completed. The LOC and needs-based eligibility assessment process and the requirements are provided in 441—Chapters 75, 78, 81, 82, 83, and 85. HCBS waiver LOC determinations must be consistent with those made for the appropriate institutional LOC under the state plan.

73.11(2) At any time, if the MCO becomes aware the enrollee's functional or medical status has changed in a way that may affect LOC or needs-based eligibility, the MCO shall submit documentation

to the department's appointed vendor to conduct an LOC or needs-based assessment. The department-approved tools shall be used to conduct an updated assessment. The updated assessment shall then be submitted to the department for determination of LOC or needs-based eligibility.
[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.12(249A) Appeal of MCP actions. The MCPs shall have written first-level appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal an MCP action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438, Subpart F.

73.12(1) *MCP appealable actions.* MCP actions that may be appealed by an enrollee may include, as cited in 42 CFR 438.400(b):

a. Denial or limited authorization of a requested service, including the type or level of service.

b. Reduction, suspension, or termination of a previously authorized service.

c. Denial, in whole or in part, of payment of service.

d. Failure to provide services in a timely manner as described by the department.

e. Failure to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b).

f. Denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCP's network related to rural access or capacity.

g. Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

73.12(2) *Appeal process.* The MCP first-level appeal process will be approved by the department and shall:

a. Allow for the appeal request to be submitted in writing or verbally.

b. Require acknowledgment of the receipt of a request for an appeal within three working days.

c. Allow for participation by the enrollee and the provider.

d. Provide for resolution of nonexpedited appeals to be concluded within 30 calendar days of receipt of the request unless an extension is requested.

e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within 72 hours of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402.

f. Ensure that the review will be made by qualified professionals who were not involved with the original action.

g. Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.
[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.13(249A) Appeal to department. If the enrollee is not satisfied with the final decision rendered by the MCP through the MCP's first-level appeal process, the enrollee may file an appeal with the department. This process is referred to as a state fair hearing, an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 2506 and federal requirements for a state fair hearing in 42 CFR 438.408(f).
[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.14(249A) Continuation of benefits. The MCP shall be required to continue the member's benefits during any appeal in accordance with federal funding requirements, including 42 CFR 438.420.

73.14(1) If the benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

a. The enrollee withdraws the appeal request;

b. Ten calendar days pass after the MCP mailed the notice providing the resolution of the appeal against the enrollee unless the enrollee, within the ten-calendar-day time frame, requests a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or

c. The time period or service limits of a previously authorized service are met.

73.14(2) If the final resolution of the state fair hearing is adverse to the enrollee, that is, it upholds the MCP's action, the MCP may recover the cost of the services furnished to the enrollee while the appeal was pending, to the extent services were furnished solely because of the requirements to maintain benefits during the appeal.

73.14(3) If the MCP or state fair hearing administrative law judge (ALJ) reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCP must authorize and provide the disputed services promptly and as expeditiously as the member's health or dental condition requires. If the MCP or the state fair hearing ALJ reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the MCP must pay for these services.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.15(249A) Grievances. The MCP shall have policies and procedures for reviewing expressions of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to quality of care or services provided, aspects of interpersonal relations such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested pursuant to 42 CFR 438.400(b). Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.16(249A) Written record. All MCP enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances pursuant to 42 CFR 438.416.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.17(249A) Information concerning procedures relating to the review of MCP decisions and actions. The MCP's written procedures for the review of MCP's decisions and actions shall be provided to each new enrollee in a member handbook, to participating providers in a provider manual, and to nonparticipating providers upon request.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.18(249A) Records and reports.

73.18(1) *Records system.* The MCPs shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including 441—Chapter 79 and 42 CFR 456, throughout the course of the contract. The records system shall:

a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.

b. Provide a rationale for, and documentation of, decisions made by the MCP based upon medical necessity.

c. Permit effective professional review for medical audit processes.

d. Facilitate an adequate system for monitoring treatment reimbursed by the MCO, including follow up of the implementation of discharge plans and referral to other providers.

73.18(2) *Content of individual treatment record.* The MCP shall ensure that participating providers maintain an adequate recordkeeping system that includes a complete medical, dental, or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of 441—Chapter 79 and pursuant to federal funding requirements, including 42 CFR 456. MCOs shall require use of an EVV system for personal care services.

73.18(3) *Confidentiality of health care, mental health care, and substance abuse information.* The MCP shall protect and maintain the confidentiality of all protected health information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.

73.18(4) *EVV system.* The MCO will participate in EVV planning activities and use the MCO-proposed, department-approved EVV system that will be in place within a time frame determined by the department to ensure compliance with state and federal regulations, including Section 12006 of the Cures Act (42 U.S.C. §1396b(1) as amended to July 1, 2026). Beginning on the dates required by the department, the MCO shall require personal care providers and home health services to use the MCO EVV system or another EVV system complying with Section 12006 of the Cures Act as amended to July 1, 2026. The MCO shall develop and describe what methodologies will be used to monitor member receipt and utilization of personal care, home health services, and other services using the EVV system. All EVV data that originates in or passes through the MCO EVV system will be provided to the department in a format and time frame subject to department approval.
[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.19(249A) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the MCP. The department or HHS may audit and inspect any records of an MCP, or the subcontractor of the MCP, that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, at places, and in a manner as authorized representatives of the department or its designee as HHS may request.
[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.20(249A) Marketing. MCP marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the MCP and contract terms. The department will approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104.
[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.21(249A) Enrollee education.

73.21(1) *Use of services.* The MCP shall provide written information to all enrollees on the use of the services the MCP is responsible to arrange, monitor, and reimburse. Information must include the array of services covered; how to access covered services; the providers participating; an explanation of the process for the review of MCP decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 2506; how to access the state fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; a statement of consumer rights and responsibilities; out-of-area use of service information; availability of toll-free telephone information and crisis assistance; and the appropriate use of the referral system.

73.21(2) *Outreach to members with special needs.* The MCP shall provide enhanced outreach to members with special needs, including but not limited to persons with a psychiatric disability, an intellectual disability or other cognitive impairments; illiterate persons; non-English-speaking persons; and persons with visual impairments or who are deaf or hard of hearing.

73.21(3) *Patient rights and responsibilities.* The MCP shall have in effect a written statement of patient rights and responsibilities that is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.
[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.22(249A) Payment to the MCP.

73.22(1) *Capitation rate.* In consideration for all services rendered by an MCP under a contract with the department, the MCP will receive a payment each month for each enrolled member. The monthly reimbursement may be reduced by amounts withheld for pay-for-performance components of the contract. The withheld amounts will be distributed based on the terms described in the MCP contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act as amended to July 1, 2026, regarding the health insurance provider's fee. This capitation rate, inclusive of the amounts withheld and the health insurance provider's fee, represents the total obligation of the department with respect to the costs of medical care and services

provided to enrolled members under the contract, except as otherwise designated in the contract rate. Pay-for-performance terms will allow for incentive reimbursement if the MCP meets metrics described in the MCP contract.

73.22(2) *Determination of rate.* The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6, Actuarial Standards of Practice 49, as amended to July 1, 2026, and other related CMS regulations and generally accepted actuarial principles and practices.

73.22(3) *Third-party liability.* If an enrolled member has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical or dental expenses, it is the right and responsibility of the MCP to investigate these third-party resources and attempt to obtain payment.

a. The MCP shall have a time limit determined by the department to attempt to collect from third-party resources.

b. The MCP shall retain all funds collected from third-party resources during the time limit.

c. A complete record of all third-party collections must be maintained and made available to the department on request.

d. In the event that the MCP no longer contracts with the department, the department has the right to seek recovery of any third-party collections not collected by the time the contract ends and retain the funds. This includes but is not limited to subrogation cases.

e. The department has the right to retain all funds collected from third-party resources after the MCP time limit.

73.22(4) *Medical loss ratio.* The MCP shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the MCP.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.23(249A) Claims payment by the MCP.

73.23(1) The MCOs shall pay or deny:

a. Ninety percent of all clean claims within 30 calendar days of receipt,

b. Ninety-nine point five percent of all clean claims within 90 calendar days of receipt, and

c. Ninety-five percent of all claims within 45 calendar days of receipt.

73.23(2) The PAHP shall pay or deny:

a. Ninety percent of all clean claims within 14 calendar days of receipt,

b. Ninety-nine percent of all clean claims within 90 calendar days of receipt, and

c. Ninety-five percent of all claims within 21 calendar days of receipt.

73.23(3) Managed care limits on payment responsibility for services.

a. The MCP is not required to reimburse providers for the provision of services that do not meet the criteria of medical necessity.

b. The MCP has the right to require prior authorization of covered services and to deny reimbursement to providers that do not comply with such requirements.

c. Payment responsibilities for emergency room services are as provided in rule 441—73.7(249A).

73.23(4) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the MCO is obligated to pay 80 percent of the payment to participating providers.

73.23(5) Timely filing. The in-network provider filing limit shall be no more than 180 days from the date of service.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.24(249A) Quality assurance. The MCP shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

441—73.25(249A) Certifications and program integrity. The MCP shall develop and implement policies, procedures, and a mandatory compliance plan to ensure compliance with the contract

requirements for certification, program integrity and prohibited affiliations. The MCP shall cooperate and collaborate with the department on all program integrity activities. The MCP shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455.

[**ARC 0312D**, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code section 249A.4.

[Filed Emergency After Notice ARC 2358C (Notice ARC 2241C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

[Filed Emergency After Notice ARC 3667C (Notice ARC 3514C, IAB 12/20/17), IAB 3/14/18, effective 2/14/18]

[Filed ARC 4392C (Notice ARC 4258C, IAB 1/30/19), IAB 4/10/19, effective 6/1/19]

[Filed ARC 4429C (Notice ARC 4289C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]

[Filed ARC 4847C (Notice ARC 4673C, IAB 9/25/19), IAB 1/1/20, effective 6/29/20]

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[Filed ARC 5597C (Notice ARC 5437C, IAB 2/10/21), IAB 5/5/21, effective 7/1/21]

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[Filed ARC 0312D (Notice ARC 9853C, IAB 12/24/25), IAB 5/27/26, effective 7/1/26]

CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

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

441—74.1(249A,249N) Definitions. The following definitions apply to this chapter in addition to the definitions in 441—Chapter 75.

"Caretaker" means the same as defined in rule 441—75.1(249A).

"Countable income" means "modified adjusted gross income" (MAGI) or "household income," as applicable, determined pursuant to 42 U.S.C. §1396a(e)(14) as amended to July 1, 2026.

"Enrollment period" means the period of time for which Iowa health and wellness plan eligibility is established.

"Essential health benefits" means the essential health benefits defined at 42 U.S.C. §18022 as amended to July 1, 2026.

"Iowa dental wellness plan" means the managed care dental benefit program set forth in 441—Chapter 73.

"Iowa health and wellness plan" or *"IHAWP"* means the medical assistance program set forth in this chapter for individuals with countable income that does not exceed 133 percent of the federal poverty level (FPL).

"Iowa wellness plan" means the benefits and services provided to IHAWP members.

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

"Medical assistance" or *"Medicaid"* means payment of all parts of the cost of the care and services made in accordance with Title XIX of the Federal Social Security Act as amended to July 1, 2026.

"Medically exempt individual" means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR 440.315 as amended to July 1, 2026.

"Minimum essential coverage" means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code as amended to July 1, 2026.

"Prepaid ambulatory health plan" or *"PAHP"* has the meaning set forth in 42 CFR 438.2 as amended to July 1, 2026.

"Qualified employer-sponsored coverage" is defined pursuant to 42 U.S.C. §1396e1(b) as amended to July 1, 2026.

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.2(249A,249N) Eligibility factors. Except as more specifically provided in this chapter, IHAWP eligibility will be determined according to the requirements of 441—Chapter 75.

74.2(1) *Persons covered.* Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under IHAWP will be available to persons 19 through 64 years of age who:

a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;

b. Have countable income at or below 133 percent of the FPL for their household size;

c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act as amended to July 1, 2026; and

d. Are not pregnant at the time of application or reenrollment.

74.2(2) *Parents or caretakers of dependent children.* All children under the age of 21 living with a parent or caretaker who will be claimed as a dependent by the parent or caretaker for state or federal income tax purposes must be enrolled in Medicaid, in the Children's Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent's or caretaker's eligibility for IHAWP benefits.

74.2(3) *Citizenship.* To be eligible for IHAWP benefits, a person must meet the citizenship requirements in 441—Chapter 75.

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.3(249A,249N) Application. Medicaid application policies and procedures described in 441—Chapter 76 apply to applications for IHAWP.
[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.4(249A,249N) Financial eligibility.

74.4(1) *Countable income.* Individuals are financially eligible for IHAWP if their countable income is no more than 133 percent of the FPL as of the date of a decision on initial or ongoing eligibility.

74.4(2) *Household size.* For financial eligibility purposes, household size will be determined according to the MAGI methodology.
[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.5(249A,249N) Enrollment period.

74.5(1) *Effective dates of eligibility.* IHAWP eligibility will 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. The enrollment period will continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,249N).

74.5(2) *Reinstatement.* Enrollment for IHAWP may be reinstated without a new application in accordance with 441—Chapter 76.

74.5(3) *Presumptive eligibility.* The enrollment period of 12 consecutive months will not apply to individuals temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity in accordance with 441—Chapter 76.

74.5(4) *Retroactive enrollment.* Medical assistance will be available to a pregnant woman or an infant (under one year of age), or a resident of a nursing facility licensed under Iowa Code chapter 135C, for all or any of the three months preceding the month in which an application is filed when eligibility requirements are met in accordance with 441—Chapter 76.
[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.6(249A,249N) Reporting changes.

74.6(1) *Reporting requirements.* In addition to the reporting requirements in 441—Chapter 76, as a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member turns 65.

d. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.

e. A child under the age of 21 living with the member loses minimum essential coverage if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.

f. The member is pregnant.

74.6(2) *Untimely report.* When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible will be considered an overpayment and be subject to recovery from the member in accordance with 441—Chapters 75 and 11. Program expenditures may include but are not limited to premiums and capitation payments.

74.6(3) *Effective date of change.* After enrollment, changes reported during the month that affect the member's eligibility will be effective the first day of the next calendar month unless:

a. Timely notice of adverse action is required as specified in rule 441—16.2(17A); or

b. The enrollment period has expired and the member is not eligible for a new enrollment period.
[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.7(249A,249N) Reenrollment. A new eligibility determination is required to establish an enrollment period. The reenrollment process will follow the requirements in 441—Chapter 76.
[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.8(249A,249N) Terminating enrollment. IHAWP enrollment ends when any of the following occurs:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.
8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.
9. The member's countable income exceeds 133 percent of the FPL.
10. IHAWP is discontinued according to the requirements in rule 441—74.14(249A,249N).
11. The member does not pay monthly contributions as required by subrule 74.11(2).

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.9(249A,249N) Recovery. The department will recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with 441—Chapter 75.

74.9(1) The department will recover Medicaid funds expended on behalf of a member from the member's estate in accordance with 441—Chapter 75.

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the department or the MCO, and an adjustment will be made to a previously submitted claim.

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.10(249A,249N) Right to appeal.

74.10(1) Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed to the extent permitted by 441—Chapter 2506.

74.10(2) Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,249N).

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.11(249A) Financial participation.

74.11(1) *Copayment.* Payment for nonemergency use of a hospital emergency department shall be subject to an $8 copayment by the member, which will be subtracted from the IHAWP payment otherwise due to the provider.

74.11(2) *Monthly contributions.* Members enrolled in the IHAWP with household income at or above 50 percent of the FPL are required to pay monthly contributions pursuant to this rule.

a. Monthly contribution amount. The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to 441—Chapter 75, as a percentage of the FPL for the household. Monthly contribution amounts are as follows:

(1) For a member with household income between 50 and 100 percent of the FPL, $5;

(2) For a member with household income above 100 percent of the FPL, $10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

(1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.

(2) The member is determined by the department to be a medically exempt individual pursuant to subrule 74.12(2).

(3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.

(4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as amended to July 1, 2026, as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning Iowa Medicaid member services, by checking the hardship box on the billing statement (for the month of the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted. Members must complete the process in every month for which they wish to claim financial hardship. There is no limit to the number of hardship exemptions for which a member may apply.

d. Billing and payment. An Iowa Medicaid billing statement form will be used for billing and collection of the monthly contribution.

(1) Method of payment. Members shall submit contribution payments to the address specified by the department. Members can also submit contributions through the department's website.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution is due on the fifteenth day of the month in which the statement is received.

2. If the fifteenth day of the month falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department will apply monthly contribution payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department will hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An IHAWP member with household income between 50 and 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) An IHAWP member with household income above 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) will have the member's eligibility terminated. In addition, the member shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions may reenroll for Medicaid benefits pursuant to 441—Chapter 76.

3. Unpaid premiums will not be considered a collectible debt by the state if, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment.

f. Refund of monthly contributions.

(1) Monthly contributions paid may be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2)*"c"* or when a member's IHAWP coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in IHAWP; or

2. The member dies.

(2) The amount of any refund will be offset by any outstanding monthly contributions owed.

(3) The refund will be paid within two calendar months from the date of termination from the program.

74.11(3) *Aggregate annual limits on copayments and monthly contributions.* The total aggregate annual amount of copayments and monthly contributions for an individual will not exceed 5 percent of the household's countable annual income determined pursuant to 441—Chapter 75.

74.11(4) *Healthy behaviors.* An IHAWP member who completes a wellness examination and health risk assessment during any enrollment year will have monthly contributions waived in the subsequent enrollment year.

a. Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a dental provider consistent with standard oral health guidelines for preventive dental examinations and as outlined in 441—Chapter 73.

b. A health risk assessment is an assessment offered by a managed care plan through which the member is receiving IHAWP benefits.

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.12(249A) Benefits and service delivery. Covered benefits and the service delivery method will be determined by the member's health status.

74.12(1) *Iowa wellness plan services.* Members shall be enrolled in IHAWP unless the member is determined by the department to be a medically exempt individual.

a. Covered Iowa wellness plan services are essential health benefits; all other benefits required pursuant to 42 U.S.C. §1396u-7(b)(1)(B) as amended to July 1, 2026, including prescription drugs; and dental services consistent with 441—Chapter 78.

b. Members enrolled in IHAWP shall be subject to enrollment in managed care, other than a program for all-inclusive care for the elderly (PACE), pursuant to 441—Chapter 73.

c. Dental services will be provided under the Iowa dental wellness plan as set forth in 441—Chapter 73 through a contract with one or more dental prepaid ambulatory health plans. The dental prepaid ambulatory health plan shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(2) *Medically exempt individuals.* An IHAWP member who has been determined by the department to be a medically exempt individual will be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A provider with a current national provider identifier number may refer a member for a medically exempt individual determination by submitting a completed form prescribed by the department.

b. Upon receipt of the appropriate forms, the department will determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR 440.315 as amended to July 1, 2026.

74.12(3) *Qualified employer-sponsored coverage.* An individual who has access to cost-effective, employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.13(249A,249N) Claims and reimbursement methodologies. Payment for services provided under the Iowa wellness plan services will be provided in accordance with 441—Chapter 79 or as provided in a contract between the department or the member's MCO and the provider.

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

441—74.14(249A,249N) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y) as amended to July 1, 2026, is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for IHAWP is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y) as amended to July 1, 2026, is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services will be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

[**ARC 0313D**, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code chapters 249A and 249N.

[Filed Emergency After Notice ARC 1135C (Notice ARC 0972C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]
[Filed Emergency ARC 1214C, IAB 12/11/13, effective 11/13/13]
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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]]

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

DIVISION I
DEFINITIONS, COVERAGE GROUPS, AND GENERAL CONDITIONS OF ELIGIBILITY

441—75.1(249A) Definitions. Unless otherwise specified, the definitions in this rule apply to 441—Chapters 74 through 88.

"Act" means the federal Social Security Act. All references to the Act herein are as amended to August 1, 2025.

"Aged" means a person 65 years of age or older.

"Applicant" means a person who is requesting medical assistance on the person's own behalf or a person for whom medical assistance is requested.

"AVS" or *"asset verification system"* means the use of an electronic asset data source to verify assets held in banks and other financial institutions for non-MAGI.

"Blind" means a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Caretaker" means an individual with whom a child is living and who assumes primary responsibility for the child's care. For this purpose, two individuals may be considered to have assumed primary responsibility for a child's care.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Child" means a natural or biological child, or an individual legally recognized as the child of a parent based on the conception, gestation, or birth of the child during a legal marriage; an adoptive child; or a child of an individual's spouse (stepchild) unless parental rights have been legally terminated.

"Client" means all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person whose income or assets are considered in determining eligibility for an applicant or member.

"Code of Federal Regulations" or *"CFR"* means the United States Code of Federal Regulations. All references to the CFR herein are as amended to August 1, 2025, unless another effective date is specified.

"Community spouse" means a noninstitutionalized spouse of an institutionalized spouse.

"Conditionally eligible" means that a person has been assigned but not met spenddown as defined in subrule 75.8(1), or has been assigned a monthly premium but has not yet paid the premium for that month pursuant to subparagraph 75.6(6)*"b"*(4).

"Coverage group" means a group of persons who meet certain common eligibility requirements.

"Dependent child" or *"dependent children"* means a child or children who meet the nonfinancial eligibility requirements of the applicable family-related coverage group.

"Electronic data sources" or *"EDS"* means federal and state data sources with which the department conducts data matches for the purpose of determining eligibility. Federal data sources include the Internal Revenue Service (IRS), the Social Security Administration (SSA) and the United States Department of Homeland Security. State data sources include Iowa workforce development (IWD) wage and unemployment compensation, SSA, IRS, and the Public Assistance Reporting Information System (PARIS).

"Family-related Medicaid" includes coverage groups that apply to children, parents and caretakers and pregnant women who are not aged, blind or disabled.

"Federal poverty level" or *"FPL"* means the levels published and updated periodically in the Federal Register by the United States Department of Health and Human Services (DHHS) under the authority of 42 U.S.C. 9902(2) and revised annually on April 1.

"General conditions of eligibility" means the eligibility criteria specified in the following provisions:

1. Rule 441—75.9(249A): furnishing of social security number.
2. Rule 441—75.10(249A): residency requirements.
3. Rule 441—75.11(249A): citizenship or alienage requirements.
4. Rule 441—75.14(249A): establishing liability and obtaining support.
5. Rule 441—75.15(249A): medical resources.
6. Rule 441—75.16(249A): medical assistance lien.
7. Rule 441—75.29(249A): investigation of eligibility.

"Income in-kind" means any gain or benefit that is not in the form of money payable directly to the applicant, member, or person whose income or assets are considered in determining eligibility for an applicant or member, including nonmonetary benefits such as meals, clothing, and vendor payments. Vendor payments are monetary payments to a third party and not to the applicant, member, or person whose income is considered in determining eligibility.

"Institutionalized person" means a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, a person who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or a person who is as described in subrule 75.6(8).

"Institutionalized spouse" means a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days and whose spouse is not in a medical institution or nursing facility.

"Local office" means the county office of the department or a state mental health institute.

"Medical institution," when used in this chapter, means a facility organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.

"Member" means any person who has been determined eligible and has been enrolled to receive medical assistance pursuant to 441—Chapter 75. "Member" may be used interchangeably with "recipient." This definition does not apply to the phrase "household member." For the medically needy program, "member" means a person who has been determined eligible for Medicaid under the medically needy program, has been approved, and has countable income at or below the medically needy income level (MNIL) or has reduced the person's countable income to the MNIL during the certification period through spenddown. Unless otherwise specified, a person is not a member for any month in which Medicaid for that person is subject to recoupment because the person was ineligible.

"Modified adjusted gross income" or *"MAGI"* means the tax-based methodology used to determine income eligibility and household size for family-related Medicaid and other coverage groups as prescribed by 1902(e)(14) of the Act (42 U.S.C. 1396a(e)(14) and 42 CFR 435.603).

"Non-MAGI-related" means those persons whose eligibility is determined using regulations governing the supplemental security income (SSI) program administered by the SSA, except that income is considered prospectively. "Non-MAGI-related" also includes persons who would be eligible for SSI except for certain eligibility factors as specified in rule 441—75.6(249A).

"Nursing facility services" means the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rules 441—75.23(249A) and 441—75.85(249A).

"Parent" means a natural or biological parent, or an individual legally recognized as the parent of a child based on the conception, gestation, or birth of the child during a legal marriage; an adoptive parent; or the spouse of another parent (stepparent) unless parental rights have been legally terminated.

"Pay and chase" means that the state pays the total amount allowed under the department's payment schedule and then seeks reimbursement from a liable third party. The pay and chase provision applies to Medicaid claims for preventive pediatric services and all services provided to a person for whom there is court-ordered medical support.

"Payee" refers to an SSI payee as defined in 20 CFR 416.601.

"Presumptive eligibility" means that a person is presumed to be eligible for Medicaid on a temporary basis based on statements provided by the person.

"Presumptive Medicaid" means immediate and temporary health care coverage based on a presumptive eligibility decision to pay for the cost of care during the presumptive period as described in subrule 75.7(4).

"Presumptive provider" means an organization approved by the department to conduct and authorize presumptive eligibility determinations pursuant to 441—subrule 76.7(1).

"Qualified entity" means an individual, under the supervision and authority of a presumptive provider, who has been determined by the department to be capable of making presumptive Medicaid eligibility determinations pursuant to 441—subrule 76.7(2).

"Reasonably compatible" or *"reasonable compatibility"* means the standard by which the total attested countable income or resources for each person's household size is compared with the total amount from available EDS or AVS used by the department. Attested income or resources must meet one of the following three criteria to meet the standards for reasonable compatibility:

1. Both the total attested income or resources and the total income or resources from the EDS or AVS are above, at, or below the applicable income or resource limit for Medicaid or hawki; or
2. The total attested income is within 10 percent of the total income from EDS or the total resources are below the resource limit for the applicable program; or
3. The total attested income or resources exceeds the total income or resources from EDS or AVS.

If the attested income or resources meet any of the reasonable compatibility criteria, the income or resources are considered to be verified.

"Reasonable opportunity period" means the 90-day period allowed for applicants and members to provide satisfactory documentation of citizenship, nationality, or qualified alien status pursuant to subparagraph 75.11(2)*"c"*(4).

"Refugee" means the same as defined in 8 U.S.C. §1101(a) INA 101 (a)(42).

"Retroactive period" means the three calendar months immediately preceding the month in which an application is filed.

"Sibling" means an individual who shares at least one common parent with another individual.

"Spouse" means a party to a legally recognized marriage, including a common-law marriage.

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent. A stepparent is considered a parent under a coverage group that is subject to MAGI methodology pursuant to 42 CFR 435.603.

"Supply" or *"supplying"* means the requested information is received by the department by the specified due date.

"Tax dependent" means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

"Transfer of assets" means the transfer of resources or income for less than fair market value as provided in rule 441—75.23(249A).

"Unborn child" includes an unborn child during the entire term of pregnancy.

"United States Code" or *"U.S.C."* means the general and permanent laws of the United States. All references to the U.S.C. herein are as amended to August 1, 2025, unless another effective date is specified.
[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.2(249A) Categories of persons covered. Persons who meet the criteria of one of the categorical groups below receive Medicaid if they meet the eligibility requirements of a related coverage group

described in rules 441—75.3(249A) through 441—75.8(249A) and the general conditions of eligibility described within this chapter.

75.2(1) *Family-related Medicaid.* Medicaid is available to the following categories of persons who meet the eligibility requirements of one of the family-related Medicaid coverage groups described in rule 441—75.3(249A), the general conditions of eligibility specified in Division I of this chapter, and the eligibility factors specific to family-related medical assistance described in Division II of this chapter unless stated otherwise within this chapter:

a. Children under the age of 19.

b. Parents and caretakers.

c. Pregnant women.

d. Persons in foster care, a subsidized adoption arrangement, or subsidized guardianship.

e. Former foster care youth.

f. Persons living in a medical institution.

75.2(2) *Persons who need breast or cervical cancer treatment.* Pursuant to rule 441—75.4(249A), Medicaid is available to persons who have been screened and found to need treatment for breast or cervical cancer.

75.2(3) *Persons aged 19 through 64.* Medicaid is available to persons who are aged 19 or older and under the age of 65 who meet the eligibility requirements of the Iowa health and wellness plan (IHAWP) as described in subrule 75.5(1) and 441—Chapter 74.

75.2(4) *Persons who are refugees.* Medicaid is available to refugees who meet the requirements described in subrules 75.5(3) and 75.5(4) and who do not meet the requirements of another Medicaid coverage group or hawki.

75.2(5) *Aged, blind, or disabled persons.* The following coverage groups are available to persons who are aged, blind, or disabled and who meet the eligibility criteria of a coverage group described in rule 441—75.6(249A) and the general conditions of eligibility specified in this chapter:

a. Persons receiving SSI or state supplementary assistance or eligible for, but not receiving, SSI.

b. Aged, blind or disabled persons ineligible for SSI or state supplementary assistance due to income or other requirements.

c. Certain persons essential to the welfare of an aged, blind, or disabled person.

d. Persons residing in a medical institution.

e. Persons participating in Medicare savings programs.

f. Working persons with disabilities.

g. Children with disabilities.

h. Persons who may be eligible for additional services that are not available through regular Medicaid, and a waiver of federal policy has been approved. These are known as waiver services and are defined in 441—Chapter 83.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.3(249A) Family-related Medicaid. Medicaid will be available to children, parents and other caretakers and to pregnant women who meet the eligibility requirements of a coverage group described within this rule and the general conditions of eligibility described in this chapter.

75.3(1) *Family medical assistance program (FMAP).* Medicaid will be available to low-income children and to the children's parent or other caretaker if the following criteria are met:

a. Children must meet the requirements described in rule 441—75.50(249A), and the parent or other caretaker must meet the requirements described in rule 441—75.51(249A).

b. Countable household income must not exceed the FMAP limits prescribed in rule 441—75.74(249A). Financial eligibility will be determined according to MAGI methodology pursuant to Division III of this chapter.

75.3(2) *Pregnant women, infants, and children (mothers and children (MAC)).* Medicaid will be available to pregnant women, infants (under one year of age), and children who have not attained the age of 19 if the following criteria are met.

a. Income.

(1) Household income must not exceed the applicable limits for the MAC program as stated in rule 441—75.74(249A).

(2) In establishing eligibility for pregnant women, infants, and children, income and household size will be determined pursuant to rule 441—75.72(249A).

(3) In establishing eligibility for a pregnant woman or any person whose MAGI household size includes a pregnant woman, the unborn child (or children) will be considered when determining the number of persons in the household. Attestation of pregnancy will be accepted in accordance with subrule 75.72(5).

b. Eligibility for pregnant women under this rule will begin no earlier than the first day of the month in which conception occurred and will continue throughout the pregnancy when requirements described in rule 441—75.18(249A) are met.

c. The effect of age on eligibility for an infant or a child will be determined pursuant to rule 441—75.52(249A).

d. When determining eligibility under this coverage group, the requirement to live with a parent or other caretaker as specified at subrule 75.50(2) and the age and school attendance provisions specified in subrule 75.50(1) do not apply.

e. A woman who was both eligible and enrolled in Medicaid on the date her pregnancy ends will be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.3(4).

f. If an infant loses eligibility under this coverage group at the time of the first birthday due to exceeding the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid will continue under this coverage group for the duration of continuous inpatient services.

75.3(3) *Newborn children.* Medicaid will be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for emergency services for labor and delivery for the child's birth. Eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department will accept any written or verbal statement as verification of the newborn's birth date unless the department determines the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility must be completed.

75.3(4) *Postpartum eligibility following pregnancy.* Medicaid will continue to be available for a period of 12 months beginning the first of the month following the end of pregnancy and continuing for 12 months for a woman who was both eligible and enrolled in Medicaid on the date her pregnancy ends.

a. Except as described in this subrule, the woman is not required to meet any eligibility criteria described in this chapter or the reenrollment requirements in rule 441—76.14(249A) during the 12-month postpartum period.

b. The woman will not be required to file an application.

c. Pregnant women determined eligible only for emergency services pursuant to subrule 75.11(4) are eligible under this provision.

75.3(5) *Healthy and well kids in Iowa (hawki).* Hawki will be available to children under the age of 19 who are not eligible for Medicaid and who meet the provisions of 441—Chapter 86.

75.3(6) *Transitional Medicaid.*

a. Eligible persons. Transitional Medicaid will be available for a period of up to 12 months to the following persons:

(1) A dependent child who becomes ineligible for FMAP due to increased income from employment of the dependent child or the child's parent or other caretaker;

(2) The child's parent or caretaker who becomes ineligible for FMAP due to increased income from employment of the dependent child or the child's parent or other caretaker; and

(3) The following household members of persons described in subparagraph 75.3(6)*"a"*(1) or *"a"*(2) who currently meet all FMAP requirements, except for income:

1. Persons who were in the home prior to FMAP discontinuance but did not receive FMAP at the time; and

2. Persons who entered the home prior to FMAP discontinuance or during the transitional Medicaid period.

b. Increase in income from employment. Increased income from employment includes but is not limited to the following:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

c. Transitional Medicaid and continuous eligibility. Transitional Medicaid eligibility rules supersede continuous eligibility rules for a child as described in rule 441—75.19(249A).

d. FMAP received in three of six months. In order to receive transitional Medicaid coverage under the provisions of this subrule, at least one of the individuals described in subparagraph 75.3(6)*"a"*(1) or *"a"*(2) must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred. The months the member receives FMAP due to continuous eligibility as described in rule 441—75.19(249A) do not count toward the transitional Medicaid requirement of receiving FMAP for at least three of the last six months. If there is an increase in income from employment when a child's continuous eligibility is ending, the child will not be redetermined to the transitional Medicaid coverage group.

e. Period of transitional coverage. The 12 months of transitional Medicaid coverage begin the day following discontinuance of FMAP eligibility and will continue for a consecutive 12-month period without regard to income changes, subject to paragraphs 75.3(6)*"g," "h,"* and *"i."*

f. Reserved.

g. Fraud. Transitional Medicaid will not be allowed under the provisions of this subrule when it has been determined that the member received FMAP in any of the six months immediately preceding the month of discontinuance as the result of fraud. Fraud is defined in accordance with Iowa Code section 239B.14.

h. Eligible child. During the transitional Medicaid period, assistance will be discontinued at the end of the first month in which there is no longer an eligible child living in the household who meets the requirements in rule 441—75.50(249A).

i. Other conditions of eligibility. Members must meet all applicable general conditions of eligibility described in this chapter except for the income limits described in rule 441—75.74(249A).

j. Transitional period ends. Transitional Medicaid will be discontinued beginning with the first month following the month in which the household no longer meets the eligibility criteria. Notice will be provided to the household in accordance with adequate and timely notice provisions as specified in rule 441—16.2(17A).

75.3(7) *Extended Medicaid.*

a. Eligible persons. Extended Medicaid will be available for a period of up to four months to the following individuals:

(1) A dependent child who becomes ineligible for FMAP due to receipt of income from alimony or other spousal support;

(2) The child's parent or caretaker who becomes ineligible for FMAP due to receipt of income from alimony or other spousal support; and

(3) The following household members of persons described in subparagraph 75.3(7)*"a"*(1) or *"a"*(2) who currently meet all FMAP requirements, except for income:

1. Persons who were in the home prior to FMAP discontinuance but did not receive FMAP at the time; and

2. Persons who enter the home prior to FMAP discontinuance or during the extended Medicaid period.

b. FMAP received in three of six months. In order to receive extended Medicaid coverage under the provisions of this subrule, at least one member must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. Period of extended coverage. The four months of extended Medicaid coverage begins the day following discontinuance of FMAP eligibility and will continue for four consecutive months, subject to paragraph 75.3(7)*"f."*

d. Reserved.

e. Other conditions of eligibility. Members must meet all applicable general conditions of eligibility described in this chapter except for the income limits described in rule 441—75.74(249A).

f. Extended period ends. Extended Medicaid will be discontinued beginning with the first month following the month in which the household no longer meets eligibility criteria. Notice will be provided to the household in accordance with adequate and timely notice provisions as specified in rule 441—16.2(17A).

75.3(8) *Children in foster care, subsidized adoption arrangement, or subsidized guardianship arrangement not eligible under Title IV-E or Title XVI of the Act.* Medicaid will be available to persons under the age of 21 if the following criteria are met:

a. For the child medical assistance program (CMAP), the person is in foster care or a subsidized adoption arrangement in accordance with subparagraph 75.3(8)*"a"*(1), *"a"*(2), or *"a"*(3) and the person is not eligible for assistance under Title IV-E or Title XVI of the Act.

(1) The person is placed in licensed foster care for which the state pays foster care maintenance payments pursuant to Iowa Code section 234.35 and rule 441—156.20(234).

(2) The person is a special needs child in an adoption assistance agreement with the department pursuant to rule 441—201.5(600), regardless of whether the adoption assistance agreement provides for adoption subsidy maintenance payments.

(3) The person is a special needs child who resides in Iowa in a private home with the child's adoptive parent(s) and is in an adoption assistance agreement with another state with which Iowa has a reciprocity agreement as follows:

1. The other state is a member of the interstate compact on adoption and medical assistance (ICAMA); and

2. The other state provides medical assistance benefits pursuant to a program funded under Title XIX of the Act under the optional group in Section 1902(a)(10)(A)(ii)(VIII) of the Act to children residing in that state (at least until aged 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Act.

b. For the subsidized guardianship medically needy program, the person resides in Iowa in a private home pursuant to a court-approved subsidized guardianship arrangement under 441—Chapter 204 and the person is not eligible for assistance under Title IV-E or Title XVI of the Act. As authorized under 42 CFR 435.308, this reasonable classification of individuals is a separate coverage group from the medical assistance available to medically needy persons described in rule 441—75.8(249A).

c. There are no financial eligibility requirements for these coverage groups.

d. The effect of reaching age 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

e. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(9) *Children in foster care, subsidized adoption arrangement, or subsidized guardianship arrangement and eligible under Title IV-E.*

a. Medicaid will be available to a child under the age of 21 who is eligible under Title IV-E of the Act and for whom any of the following is provided:

(1) Foster care maintenance payments for a child placed in licensed foster care pursuant to Iowa Code section 234.35 and rule 441—156.20(234).

(2) Guardianship assistance pursuant to rule 441—204.4(234), regardless of whether the guardianship assistance agreement provides for guardianship subsidy maintenance payments.

(3) Adoption assistance pursuant to rule 441—201.5(600), regardless of whether the adoption assistance agreement provides for adoption subsidy maintenance payments.

b. IV-E assistance from another state. Medicaid will be available to children under the age of 21 who are eligible for federal foster care maintenance payments, adoption assistance, or guardianship assistance

under Title IV-E of the Act from another state and live in Iowa, including children with an adoption or guardianship assistance agreement that does not provide for maintenance payments.

c. There are no financial eligibility requirements for these coverage groups.

d. The effect of reaching age 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

e. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(10) *State-only funded medical assistance for children in foster care or a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.*

a. When the department is responsible for foster care maintenance payments for a child placed in licensed foster care pursuant to Iowa Code section 234.35 and rule 441—156.20(234), or has negotiated an adoption assistance agreement pursuant to rule 441—201.5(600) for a child living in a private home regardless of whether the agreement provides for adoption subsidy maintenance payments, state-only funded medical assistance will be available to the child if:

(1) The child is under the age of 21, lives in Iowa, and is not otherwise eligible under a category for which federal financial participation is available; or

(2) The child is under the age of 21, lives in another state, and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the Act, notwithstanding the residency requirements of 441—75.10(249A).

b. There are no financial eligibility requirements for this coverage group.

c. The effect of reaching the age of 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

d. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(11) *State-only funded medical assistance for children in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.*

a. When the department has negotiated a subsidized guardianship agreement for a child pursuant to 441—Chapter 204, state-only funded medical assistance will be available to the child under this subrule if the child is under the age of 21 and living in a private home pursuant to a court-approved subsidized guardianship agreement if:

(1) The child lives in Iowa and is not eligible for Medicaid under a category for which federal financial participation is available due to reasons other than:

1. Failure to provide information, or
2. Failure to comply with other procedural requirements; or

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

1. Failure to provide information, or
2. Failure to comply with other procedural requirements.

b. There are no financial eligibility requirements for this coverage group.

c. The effect of reaching the age of 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

d. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(12) *Medicaid for former foster care youth (EMIYA).* Medicaid will be available to a person who meets all of the following conditions:

a. The person is at least 18 years of age (or such higher age to which foster care is provided to the person, as provided in paragraph 75.3(12)*"c"*) and under 26 years of age. The effect of reaching the age of 26 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

b. The person is:

(1) Not described in and is not enrolled under any of subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Act; or

(2) Described in any of such subclauses but has income that exceeds the level of income applicable under Iowa's state Medicaid plan for eligibility to enroll for Medicaid under such subclause.

c. The person was in foster care as defined in Iowa Code section 232.2(20B):

(1) Under the responsibility of Iowa or a tribe within Iowa on the date of attaining 18 years of age or such higher age as described in Iowa Code section 234.1 on or prior to December 31, 2022; or

(2) Under the responsibility of any state on the date of attaining 18 years of age or such higher age as defined under Section 1902(a)(10)(A)(i) of the Act on or after January 1, 2023.

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Act on the date of attaining 18 years of age or such higher age as described in Iowa Code section 234.1 on or prior to December 31, 2022; or

e. The person was enrolled in Medicaid in any state on the date of attaining 18 years of age or such higher age as defined under Section 1902(a)(10)(A)(i) of the Act on or after January 1, 2023.

f. There are no financial eligibility requirements for this coverage group.

75.3(13) *Persons under 21 receiving care in a medical facility who would be eligible under a special income standard.* Medicaid will be available to persons under the age of 21 who meet the requirements in paragraph 75.6(4)*"b."*

75.3(14) *Presumptive eligibility for family-related medical assistance.* Medicaid will be temporarily available to the following persons who are determined to be presumptively eligible for Medicaid pursuant to rule 441—75.7(249A):

a. Infants (within MAC income limits specified in rule 441—75.74(249A));

b. Children (within hawki income limits specified in 441—subrule 86.2(2));

c. Parents and other caretakers (within FMAP income limits specified in rule 441—75.74(249A));

d. Pregnant women (within MAC income limits specified in rule 441—75.74(249A)); and

e. EMIYA.

75.3(15) *Family-related medically needy.* Pursuant to rule 441—75.8(249A), Medicaid will be available to children under the age of 19 and pregnant women who would be eligible for a family-related coverage group except for excess income. The coverage group is also available to a "parent" and "caretaker" as defined in rule 441—75.1(249A) who meet the requirements described in rule 441—75.8(249A) and who would be eligible for a family-related coverage group or IHAWP except for excess income.

This rule is intended to implement Iowa Code sections 249A.3, 249A.3A and 249A.4.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.4(249A) Persons who have been screened and found to need breast or cervical cancer treatment (BCCT).

75.4(1) Medicaid is available to persons who meet the eligibility requirements described within this rule and the general conditions of eligibility described in this chapter.

a. Medicaid will be available to persons who:

(1) Are under the age of 65:

(2) Have been screened for breast or cervical cancer under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) established under Title XV of the Public Health Service Act as amended to August 1, 2025, and have been found to need BCCT (including a precancerous condition);

(3) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg-3(c)(1)). An individual is not considered to have creditable coverage just because the individual may receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian Organization; and

(4) Are not eligible for Medicaid under Iowa Code section 249A.3(1).

b. Eligibility established under this subrule continues until the person is:

(1) No longer receiving BCCT;

(2) Aged 65 or older; or

(3) Covered by creditable coverage or eligible for Medicaid under Iowa Code section 249A.3(1).

c. Persons applying for this coverage group are not subject to MAGI methodologies described in Division III of this chapter. Income eligibility is determined by the NBCCEDP.

75.4(2) Presumptive eligibility. Medicaid is temporarily available to persons who have been screened for breast or cervical cancer and found to need treatment for the cancer and who are determined to be presumptively eligible for Medicaid under BCCT pursuant to rule 441—75.7(249A).
[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.5(249A) Persons under age 65; refugees. Medicaid is available to persons who are under age 65 and to persons admitted to the United States as refugees who meet the eligibility requirements of a coverage group described within this rule.

75.5(1) *Iowa health and wellness plan (IHAWP).* This coverage group is available to persons who are aged 19 or older and under the age of 65 who meet the eligibility requirements of the IHAWP as described in 441—Chapter 74 and who are not eligible for Medicaid under a family-related or non-MAGI-related coverage group.

75.5(2) *Presumptive eligibility for IHAWP.* Medicaid will be temporarily available to persons who are aged 19 or older and under the age of 65 who are determined to be presumptively eligible for IHAWP medical assistance pursuant to rule 441—75.7(249A).

75.5(3) *Refugee medical assistance (RMA).* RMA is available to refugees, subject to the time limit set forth in rule 441—60.7(217) and paragraph 75.5(3)*"a,"* when the requirements of this rule are met and eligibility does not exist under another Medicaid coverage group or hawki.

a. The time limit begins the month of entry, regardless of which day during the month is the refugee's date of entry. The time limit applies to each person, not to each case or household.

b. The refugee must meet the immigration status and other non-financial requirements described in 441—Chapter 60.

c. Financial eligibility will be determined according to MAGI methodology pursuant to Division III of this chapter. Countable household income must not exceed the FMAP limits prescribed at rule 441—75.74(249A).

d. For purposes of Medicaid, the refugee is not required to meet the work and training requirements specified in rule 441—60.9(217).

75.5(4) *Extended coverage for refugees.* RMA will be available to a refugee for the remainder of the time limit described in subrule 75.5(3) when the refugee, who is a member, becomes ineligible for RMA or Medicaid under another coverage group solely due to earnings of a household member and eligibility does not exist under another coverage group.

a. A refugee will not be required to meet any minimum program participation time frames to receive RMA coverage under this subrule.

b. A person who returns to the household after the family becomes ineligible for RMA or Medicaid may be included in the extended RMA household if the person was included in the RMA or Medicaid household the month the family became ineligible for RMA or other Medicaid.
[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.6(249A) Aged, blind or disabled. Medicaid is available to persons who are aged, blind or disabled and who meet the eligibility requirements of a coverage group described within this rule, the general conditions of eligibility, and the eligibility factors specific to non-MAGI-related Medicaid described in Division IV unless stated otherwise within this chapter.

75.6(1) *Persons receiving SSI or state supplementary assistance; persons eligible for but not receiving SSI.*

a. SSI recipients. Medicaid will be available to all persons receiving SSI payments as authorized by the SSA under Title XVI of the Act.

b. State supplementary assistance recipients. Medicaid will be available to all recipients of state supplementary assistance as authorized by Iowa Code chapter 249, 441—Chapters 50 through 54 and 177, and Title XVI of the Act. This applies to mandatory and optional state supplementary assistance payments, whether administered by the department or the SSA.

c. Persons who meet the income and resource requirements of SSI. Medicaid will be available to aged, blind, or disabled persons as described below who meet the income and resource guidelines of SSI but who are not receiving SSI:

(1) Aged and blind persons, as defined in rule 441—75.1(249A).

(2) Disabled persons, as determined pursuant to rule 441—75.81(249A).

(3) In establishing eligibility for children for this coverage group, resources of the child and ineligible parent or stepparent, regardless of age, will be disregarded.

(4) In establishing eligibility for adults for this coverage group, resources of non-MAGI persons will be treated according to SSI policies.

d. Persons who do not receive an SSI payment but are considered as SSI recipients. Medicaid will be available to a person who is not receiving an SSI payment because the SSA has determined that the person exceeds the income limit when the department still considers the person to be an SSI recipient.

75.6(2) *Persons who are not eligible for SSI or state supplementary assistance.*

a. Persons who are ineligible for SSI because of requirements that do not apply under Title XIX of the Act. Medicaid will be available to persons who would be eligible for SSI except for an eligibility requirement used in that program that is specifically prohibited under Title XIX of the Act.

b. Persons who would be eligible for SSI or state supplementary assistance but for social security cost-of-living increases received. Medicaid will be available to all current social security recipients who meet the following conditions:

(1) They were entitled to and received concurrently in any month after April 1977 SSI and social security or state supplementary assistance and social security,

(2) They subsequently lost eligibility for SSI or state supplementary assistance, and

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

c. Persons who would be eligible for SSI or state supplementary assistance, except that they receive social security benefits from a parent's account based on disability. Medicaid will be available to persons who receive SSI or state supplementary assistance after their eighteenth birthday because of a disability or blindness that began before the age of 22 and who would continue to receive SSI or state supplementary assistance except that they become entitled to or receive an increase in social security benefits from a parent's account.

d. Persons ineligible due to October 1, 1972, social security increase. Medicaid will be available to persons and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these persons and families would be eligible for an assistance grant if the increase were not considered.

e. Persons who would be eligible for SSI or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received. Medicaid will be available to all current social security recipients who meet all of the following conditions:

(1) They were eligible for a social security benefit in December of 1983.

(2) They were eligible for and received a widow's or widower's disability benefit and SSI or state supplementary assistance for January of 1984.

(3) They became ineligible for SSI or state supplementary assistance because of an increase in their widow's or widower's benefit that resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

(4) They have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

(5) They would be eligible for SSI or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

(6) They submitted an application prior to July 1, 1988.

f. Widows and widowers who are no longer eligible for SSI or state supplementary assistance because of the receipt of social security benefits. Medicaid will be available to widows and widowers who meet the following conditions:

(1) They have applied for and received or were considered recipients of SSI or state supplementary assistance.

(2) They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

(3) They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

(4) They are no longer eligible for SSI or state supplementary assistance solely because of the receipt of their social security benefits.

g. Continued Medicaid for disabled children from August 22, 1996. Medicaid will be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104-193) as amended to August 1, 2025, and 42 U.S.C. 1382c(a)(3).

75.6(3) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medicaid will be available to the person living with and essential to the welfare of a Title XVI beneficiary, provided the essential person was eligible for Medicaid as of December 31, 1973. The person will continue to be eligible for Medicaid as long as the person continues to meet the definition of "essential person" in effect for the Old Age Assistance, Aid to the Blind, or Aid to the Permanently and Totally Disabled public assistance programs on December 31, 1973, and as determined by SSA.

75.6(4) *Persons residing in a medical institution.*

a. Persons who would be eligible for SSI or state supplementary assistance except for their institutional status. Medicaid will be available to persons receiving care in a medical institution who would be eligible for SSI or state supplementary assistance if they were not institutionalized.

b. Persons receiving care in a medical facility who would be eligible under a special income standard.

(1) Medicaid will be available to persons who:

1. Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.2(249A), 441—82.6(3) and 441—82.7(249A).

2. Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the intellectually disabled (ICF-ID), or Medicare-certified skilled nursing facility.

3. Have gross countable monthly income that does not exceed 300 percent of the federal SSI benefits for one.

4. Either meets all SSI eligibility requirements except for income or is under age 21 pursuant to subrule 75.3(14).

(2) For all persons in this coverage group, income will be considered as provided for non-MAGI-related coverage groups under rule 441—75.80(249A). In establishing eligibility for persons aged 21 or older for this coverage group, resources will be considered as provided for non-MAGI-related coverage groups.

(3) A person in this group will not be eligible until the person has been institutionalized for a period of 30 consecutive days, and eligibility will be effective no earlier than the first day of the month in which the 30-day period begins. A period of 30 days means beginning from 12 a.m. of the day of admission to the medical institution and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

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

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

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

75.6(5) *Medicare savings programs.* The purpose of the coverage groups within this subrule is to assist low-income persons with the payments of Medicare premiums, coinsurance, and deductibles. These groups are known as Medicare savings programs.

a. Qualified Medicare beneficiary (QMB) program.

(1) Medicaid will be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance, and deductibles, providing the following conditions are met:

1. The person's monthly income does not exceed 100 percent of the FPL applicable to the family size.

2. The amount of income will be determined as under the SSI program.

3. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in Section 1905(p)(1)(C) of the Act.

(2) The amount of resources will be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility is the first of the month after the month of decision.

(5) Pursuant to 42 CFR 435.909(b), SSI recipients are automatically enrolled in the QMB group.

b. Qualified disabled and working persons. Medicaid will be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

(1) Qualified disabled and working persons are persons who meet the following requirements:

1. The person's monthly income does not exceed 200 percent of the applicable FPL for the family size.

2. The person's resources do not exceed twice the maximum amount allowed under the SSI program.

3. The person is not eligible for any other Medicaid benefits.

4. The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Act (as added by Section 6012 of the Omnibus Budget Reconciliation Act (OBRA) 1989).

(2) The amount of the person's income and resources will be determined as under the SSI program.

c. Specified low-income Medicare beneficiaries.

(1) Medicaid will be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

1. The person's monthly income exceeds 100 percent of the FPL but is less than 120 percent of the FPL applicable to a family of the size involved.

2. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in section 1905(p)(1)(C) of the Act.

(2) The amount of income and resources will be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility will be as set forth in 441—subrule 76.13(1).

d. Expanded specified low-income Medicare beneficiaries.

(1) Medicaid benefits to cover the cost of the Medicare Part B premium will be available to persons who are entitled to Medicare Part A provided the following conditions are met:

1. The person is not otherwise eligible for Medicaid.

2. The person's monthly income is at least 120 percent of the FPL but is less than 135 percent of the FPL applicable to a family of the size involved.

3. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in Section 1905(p)(1)(C) of the Act.

(2) The amount of the income and resources will be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility will be as set forth in 441—subrule 76.13(1).

75.6(6) *Medicaid for employed people with disabilities (MEPD).*

a. Medicaid will be available to persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.81(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.

(2) They are less than 65 years of age.

(3) They are members of families (including families of one) whose income is less than 250 percent of the FPL for the family. Family income will include gross income of all family members, less SSI program disregards, exemptions, and exclusions, including the earned income disregards. The social security cost-of-living increase will be excluded in the current calendar year for January until April.

(4) They receive earned income from employment or self-employment or are eligible pursuant to paragraph 75.6(6)*"c."*

(5) They would be eligible for Medicaid under another coverage group set out in this rule (other than the medically needy coverage groups in rule 441—75.8(249A)), disregarding all income, up to $10,000 of available resources for an individual and $21,000 for a couple, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account.

(6) They have paid any premium assessed pursuant to paragraph 75.6(6)*"b."*

b. Persons whose gross income is greater than 150 percent of the FPL.

(1) For a person whose gross income exceeds 150 percent of the FPL for an individual, eligibility is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social security cost-of-living adjustment will be included only in determining premium liability based on a subsequently published FPL. A monthly premium will be assessed at the time of application and at the annual review. The premium amounts and the FPL increments above 150 percent of the FPL used to assess premiums will be adjusted annually on August 1.

(2) Beginning with the month of application, the monthly premium amount will be established based on projected average monthly income. The monthly premium established will not be increased for any reason before the next eligibility review. The premium will not be reduced due to a change in the FPL but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(3) Eligible persons are required to complete and return forms specified by the department with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(4) Premiums will be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	$44
165% of Federal Poverty Level	$60
180% of Federal Poverty Level	$72
200% of Federal Poverty Level	$84
225% of Federal Poverty Level	$99

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
250% of Federal Poverty Level	$115
300% of Federal Poverty Level	$144
350% of Federal Poverty Level	$175
400% of Federal Poverty Level	$206
450% of Federal Poverty Level	$238
550% of Federal Poverty Level	$296
650% of Federal Poverty Level	$358
750% of Federal Poverty Level	$421
850% of Federal Poverty Level	$497
1000% of Federal Poverty Level	$597
1150% of Federal Poverty Level	$699
1300% of Federal Poverty Level	$806
1480% of Federal Poverty Level	$931

(5) Eligibility is contingent upon the payment of any assessed premiums. Medicaid eligibility will not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(6) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover.

EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility will be canceled.

(7) Payments received will be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments will be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess will be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs 75.6(6)*"b"* (7)"1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account will be refunded to the client after two calendar months of inactivity, or no longer being assessed a monthly premium, or upon request from the client.

(8) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

(9) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to the MEPD billing statement.

(10) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(11) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will be provided in accordance with 441—Chapter 16 and will include reopening provisions that apply if payment is received, as well as appeal rights under 441—Chapter 2506.

(12) A form specified by the department will be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment will remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit a form prescribed by the department to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices, and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices, or assistive technology services. Assistive technology accounts must be held separate from other accounts, and funds 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 the age of 18 and unmarried, includes parents living with the individual, unmarried siblings under the age of 18 and living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, "family" includes the individual's spouse living with the individual and any children living with the individual who are under the age of 18 and unmarried. No other persons will be considered members of an individual's family. An individual living alone or with others not listed above will be considered to be a family of one.

"Medical savings account" means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. §220).

"Retirement account" means any retirement or pension fund or account, listed in Iowa Code section 627.6(8)*"f"* as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.6(7) *Medicaid for kids with special needs (MKSN).* Medicaid will be available to children who meet all of the following conditions on or after January 1, 2009:

a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.81(249A) based on the disability standards for children used for SSI benefits under Title XVI of the Act but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child's household has income at or below 300 percent of the FPL applicable to a family of that size.

(1) For this purpose, the child's household includes any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's unmarried siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph 75.6(7)*"d"*(1) will be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs is not considered to be "receiving Medicaid" for the purposes of subparagraph *"d"*(1). A child who lives alone or with persons not identified in subparagraph *"d"*(1) will be considered as having a household of one.

(3) For this purpose, all unearned and earned income of the household, unless specifically exempted, disregarded, deducted for work expenses, or diverted, will be considered in determining initial and continuing eligibility.

75.6(8) *Persons eligible for waiver services.* Medicaid will be available to members eligible for waiver services as defined in 441—Chapter 83.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26; **ARC 0396D**, IAB 6/24/26, effective 8/1/26]

441—75.7(249A) Presumptive eligibility. Medicaid will be temporarily available to persons who are determined to be presumptively eligible for Medicaid pursuant to this subrule. Presumptive eligibility will be determined by a qualified entity (QE) and will be based solely on the applicant's attested circumstances as provided to the QE and entered by the QE directly online into the Medicaid Presumptive Eligibility Portal (MPEP) system. Verification cannot be requested or required for a presumptive eligibility determination.

75.7(1) *Application process.* Persons and families requesting assistance under this subrule shall apply with a QE using the methods described in 441—subrule 76.7(3). The requirements for filing date of application, effective date of coverage, signature on application, notice and appeal rights, and full Medicaid eligibility determinations described in 441—subrules 76.7(4) through 76.7(7) apply.

75.7(2) *Eligibility requirements applicable to all presumptive eligibility determinations except as stated otherwise within this rule.* The following eligibility requirements are applicable to all presumptive eligibility determinations, except as stated otherwise within this rule.

a. Household size. Household size will be determined using MAGI methodology as described in rule 441—75.72(249A).

b. Countable income. Countable income will be determined using MAGI methodology as described in rule 441—75.73(249A).

c. Citizenship or qualified noncitizen status. The person for whom assistance is requested must be a citizen of the United States or a qualified noncitizen as defined in 441—75.11(249A), except for a pregnant woman described in paragraph 75.7(3)*"c."*

d. Iowa residency. The person for whom assistance is requested must be a resident of Iowa as described in rule 441—75.10(249A).

e. Prior presumptive eligibility. A person will not be determined presumptively eligible more than once in a 12 calendar month period, except as allowed in paragraph 75.7(3)*"g."* The first month of the 12 calendar month period begins with the calendar month the application is received by the qualified entity.

75.7(3) *Categories of eligibility and specific requirements.* The following categories of persons are eligible for a presumptive determination. Persons applying for a presumptive determination must meet all specific requirements related to the category of coverage in addition to the requirements in subrule 75.7(2), except as stated otherwise within this subrule. For categories where age is an eligibility factor, the effect of reaching an age limit on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

a. Presumptive eligibility for children. Presumptive eligibility is available to children who meet the following requirements:

(1) Age—the child must be under the age of 19 as described in rule 441—75.52(249A).

(2) Income limits—household income must not exceed:

1. The MAC program limit for infants and the applicable household size as specified in rule 441—75.74(249A) when the child is under the age of one; or

2. The hawki program limit for a household of the same size as specified in 441—subrule 86.2(2) when the child is aged 0 through 18.

b. Presumptive eligibility for parents and other caretakers. Presumptive eligibility will be available to a parent or other caretaker who meets the following requirements:

(1) Household income must not exceed the family medical assistance program income limits specified in rule 441—75.74(249A).

(2) The parent or caretaker lives with a dependent child as described in subrule 75.50(2) and has primary responsibility for the child's care as described in subrule 75.51(2).

c. Presumptive eligibility for pregnant women. Presumptive eligibility for ambulatory prenatal care is available to a woman who is pregnant and who also meets the following requirements:

(1) Household income must not exceed the MAC program limit for pregnant women specified at rule 441—75.74(249A) for the applicable household size.

(2) A pregnant woman will not be required to meet the citizen or noncitizen requirements of rule 441—75.11(249A).

d. Presumptive eligibility for IHAWP. Presumptive eligibility for IHAWP is available to a person who meets the following requirements:

(1) The non-financial eligibility requirements described in rule 441—74.2(249A,249N).

(2) Household income not exceeding 133 percent of the FPL based on the size of the household pursuant to rule 441—74.4(249A,249N).

e. Presumptive eligibility for former foster care youth. Presumptive eligibility will be available to a person who is under the age of 26, was formerly in foster care, and meets the requirements described in subrule 75.3(12).

f. Presumptive eligibility for persons who have been screened and found to need treatment for breast or cervical cancer. Presumptive eligibility is available to a person who has been screened and found to need treatment for either breast or cervical cancer, subject to the following:

(1) The person must be determined to meet the eligibility requirements described in subrule 75.4(1).

(2) The person will not be required to meet the eligibility requirements described in paragraph 75.7(2) *"a," "b,"* or *"c."*

g. Presumptive eligibility more than once in a 12 calendar month period. A person will be determined presumptively eligible only once in a 12 calendar month period beginning with the calendar month the application is received by the qualified entity, except as follows:

(1) A new period of presumptive eligibility will begin each time a person is screened as described in subparagraph 75.4(1)*"a"* and determined to need treatment for a new occurrence of breast or cervical cancer.

(2) A pregnant woman may be determined presumptively eligible for Medicaid once per pregnancy but no more than once per pregnancy.

75.7(4) *Presumptive eligibility period.* Presumptive eligibility is effective on the date that a qualified entity completes the presumptive eligibility determination pursuant to 441—subrule 76.7(5) and ends as described in the paragraphs below.

a. For persons determined presumptively eligible under paragraphs 75.7(3)*"b"* through *"f,"* presumptive eligibility will continue until:

(1) In the case of a person on whose behalf a Medicaid application has not been filed, the last day of the calendar month following the month of the presumptive eligibility determination; or

(2) In the case of a person on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application. Withdrawal of a Medicaid application before a decision is made will not affect the person's eligibility during the presumptive period.

b. For children determined presumptively eligible under paragraph 75.7(3)*"a,"* presumptive eligibility will continue until:

(1) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the calendar month following the month of the presumptive eligibility determination; or

(2) In the case of a child on whose behalf a Medicaid (including hawki) application has been filed, the day the child is determined eligible for Medicaid, the last day of the month before the child is determined eligible for hawki, or the day the child is determined ineligible for both Medicaid and hawki. Withdrawal of a Medicaid (including hawki) application before a decision is made will not affect the child's eligibility during the presumptive period.

75.7(5) *Services covered.*

a. Persons determined presumptively eligible under paragraphs 75.7(3)*"a," "b," "e,"* and *"f"* will be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services for children. Payment of claims for Medicaid services provided during the presumptive period is not dependent upon the department's determination of Medicaid or hawki eligibility.

b. Covered services for pregnant women determined presumptively eligible under paragraph 75.7(3)*"c"* will be limited to ambulatory prenatal care services during the presumptive period. Payment of claims for ambulatory prenatal care services is not dependent upon a determination of Medicaid eligibility by the department. "Ambulatory prenatal care" means all Medicaid-covered services, except inpatient hospital or institutional care and charges associated with delivery of the baby (including miscarriage or termination of a pregnancy).

c. Persons determined presumptively eligible under paragraph 75.7(3)*"d"* will be limited to all services offered under IHAWP pursuant to 441—Chapter 74. Payment of claims for services offered under IHAWP and provided during the presumptive eligibility period is not dependent upon the department's determination of IHAWP eligibility.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.8(249A) Medically needy persons.

75.8(1) *Medically needy definitions.* For purposes of this rule, the following definitions apply:

"Break in assistance" for medically needy means the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

"Certification period" for medically needy means the period of time not to exceed two consecutive months in which a person is conditionally eligible.

"Client" for medically needy means all of the following:

1. A medically needy applicant;
2. A medically needy member;
3. A person who is conditionally eligible for Medicaid under the medically needy coverage group; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

"Conditionally eligible" means that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period.

"Family-related medically needy" means those persons who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income.

"FMAP-related medically needy" means those persons who would be eligible for FMAP pursuant to subrule 75.3(1) except for excess income.

"Incurred medical expenses" for the medically needy program means:

1. Medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or
2. Unpaid medical expenses for which the client or responsible relative remains obligated.

"Member" for the medically needy program means a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown.

"Necessary medical and remedial services" for the medically needy program means medical services recognized by law that are currently covered under the Medicaid program.

"Needy specified relative" means a nonparental specified relative, as defined for the family investment program (FIP) in rule 441—40.21(239B), who meets all of the eligibility requirements of the FMAP coverage group pursuant to subrule 75.3(1).

"Noncovered Medicaid services" for the medically needy program means medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones that are otherwise not covered under Medicaid, the bill is for a responsible relative who is not included in the Medically needy eligibility determination pursuant to subrule 75.8(3) or the bill is for services delivered before the start of a certification period.

"Obligated medical expense" for the medically needy program means a medical expense for which the client or responsible relative continues to be legally liable.

"Ongoing eligibility" for the medically needy program means that eligibility continues for an SSI-related, family-related, or FMAP-related medically needy person with a zero spenddown.

"Recertification" in the medically needy coverage group means establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Responsible relative" for medically needy means a spouse, parent, or stepparent of the applicant or member who lives with the applicant or member.

"Retroactive certification period" for the medically needy program means one, two, or three calendar months prior to the date of application. When applicable pursuant to 441—subrule 76.13(3), the retroactive certification period begins with the first day of the first month within the three-month period that Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" means the three calendar months immediately preceding the month in which an application is filed and applies when applicable pursuant to 441—subrule 76.13(3).

"Spenddown" means the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

"SSI-related medically needy" means those persons whose eligibility is determined using regulations governing the supplemental security income (SSI) program except for income or resources.

75.8(2) *Coverage groups.* Medically needy will be available to the following persons who meet the general conditions of eligibility described in this chapter:

a. Pregnant women. Pregnant women who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income. For family-related programs, pregnant women will have the unborn child or children counted in the household size as if the child or children were born and living with them pursuant to subrule 75.72(5).

b. FMAP-related persons under 19. Persons under the age of 19 who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income.

c. SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

d. FMAP-related parents and caretakers. Parents and caretakers who:

(1) Meet the requirements of rule 441—75.51(249A) and whose income exceeds the limits for FMAP; and

(2) Live with a dependent child who meets the requirements of rule 441—75.50(249A).

75.8(3) *Family-related eligible group.*

a. The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive SSI under Title XVI of the Act. There will be at least one eligible parent or needy specified relative and at least one dependent child in the eligible group, except when the only eligible child is receiving SSI. The parent or needy specified relative may be the only FMAP-related eligible group member receiving Medicaid if:

(1) The only dependent child receives SSI, or

(2) The dependent child is ineligible for Medicaid, or

(3) The parent or needy specific relative voluntarily chooses to exclude the dependent child or children in order to receive coverage for the parent or needy relative.

b. The following persons will be included (except as otherwise provided in these rules) without regard to the person's employment status, income, or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children if the parent is living in the same home as the dependent children.

c. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as payee when the parent is in the home but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent and the incapacitated stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be obtained from either an independent licensed physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on a form specified by the department. When an examination is required and other resources are not available to meet the expense of the examination, the physician will be authorized to make the examination and submit the claim for payment on a form specified by the department. A finding of eligibility for social security benefits or SSI benefits based on disability or blindness is acceptable proof of incapacity.

75.8(4) *Resources and income of all persons considered.*

a. Resources of all parents and other caretakers and of all potentially eligible individuals living together, except as specified at paragraph 75.8(4)*"b"* or those excluded in accordance with the provisions of paragraph 75.8(4)*"d,"* will be considered in determining eligibility of adults. Resources of all parents and other caretakers and of all potentially eligible individuals living together will be disregarded in determining eligibility of children. Income of all parents and other caretakers and of all potentially eligible individuals living together, except as specified in paragraph 75.8(4)*"b"* or those excluded in accordance with the provisions of paragraph 75.8(4)*"d,"* will be considered in determining eligibility.

b. The amount of income of the responsible relative that has been counted as available to a family-related household other than the medically needy applicant or member household or SSI individual will not be considered in determining the countable income for the medically needy applicant or member household.

c. The resource determination will be according to subrules 75.82(3) and 75.82(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

d. Certain persons may be voluntarily excluded from the family-related medically needy eligibility determination as follows:

(1) Exclusions from the eligibility determination. In determining eligibility under the family-related medically needy coverage groups described in paragraphs 75.8(2)*"a," "b,"* and *"d,"* the following persons may be excluded from consideration when determining medically needy eligibility of other household members:

1. Siblings (of whole or half blood, or adoptive) of eligible children.
2. Self-supporting parents of minor unmarried parents.
3. Stepparents of eligible children.
4. Children living with a parent or caretaker.

(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded will also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent will not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent will be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the legally recognized natural or adoptive parent will not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the

income and resources of the natural or adoptive parent will be used in determining eligibility for the natural or adoptive parent's children.

(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination will not be entitled to Medicaid under this or any other coverage group.

(4) Situations where a parent's needs are excluded. In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent will be allowed the earned income deduction, child care expenses, and work incentive disregard as provided at paragraph 75.8(6)*"a."*

(5) Situations where a child's needs, income, and resources are excluded. In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subparagraph 75.8(4)*"d"*(2), and the child's income is not sufficient to meet the child's needs, the parent will be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted will be the difference between the schedule of basic needs of all potentially eligible individuals living together with the child included and the schedule of basic needs with the child excluded, in accordance with the FIP provisions in 441—subrule 41.28(2), minus any countable income of the child.

75.8(5) *Resources.*

a. The resource limit for adults in SSI-related households will be $10,000 per household.

b. Disposal of resources for less than fair market value by SSI-related applicants or members is governed by rule 441—75.23(249A).

c. The resource limit for family-related adults will be $10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the medically needy household, regardless of age, will be disregarded. In establishing eligibility for adults for this coverage group, resources will be considered according to rule 441—41.26(239B).

d. The resources of SSI-related persons will be treated according to SSI policies.

e. When a resource is jointly owned by SSI-related persons and family-related persons, the resource will be treated according to SSI policies for the SSI-related person and according to the policies described in paragraph 75.8(5)*"c"* for the family-related persons.

75.8(6) *Income.* All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted, will be considered in determining initial and continuing eligibility.

a. Income policies for family-related medically needy coverage groups. MAGI income and household size policies do not apply to the family-related medically needy coverage groups described in subrule 75.8(2). When determining eligibility for a family-related medically needy coverage group described in subrule 75.8(2), the department will determine countable income as described in the following subparagraphs.

(1) Earned income. "Earned income" means income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment.

(2) Earned income deductions. Deductions from earned income will be made as follows:

1. Each person in the household whose gross nonexempt earned income is considered in determining eligibility is entitled to one 20 percent earned income deduction from the monthly gross earnings. The deduction is intended to include work-related expenses other than child care such as taxes, transportation, meals, and uniforms.

2. Each person in the household is entitled to a deduction for child or incapacitated adult care expenses for employment-related hours subject to the following limitations:

- The going rate in the community up to $175 per month for each child aged two or older or each incapacitated adult.
- The going rate in the community up to $200 per month for each child under the age of two.
- No deduction is allowed for any portion of the cost of care that is paid for by a third party such as but not limited to the child care assistance program.
- Stepparents and self-supporting parents on minor parent cases will be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

- No deduction is allowed when both parents are in the home and one parent is not employed during the hours that care is needed if the parent at home during those hours is physically and mentally able to provide the care.
- A deduction is allowable only when the care covers the actual employment hours plus a reasonable period of time for commuting, or the period of time when the person who would normally care for the child or incapacitated adult is employed at such hours that the person is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.
- Any special needs of a physically or mentally handicapped child or adult will be taken into consideration in determining the deduction allowed.
- If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense will be allowed when paid to any person except a parent or legal guardian of the child or another member of the household.

(3) With respect to self-employment, a person is considered to be self-employed if the requirements of FIP in 441—subrule 41.27(2) are met. Income will be considered earned income when it is produced as a result of the performance of services by an individual.

1. Earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income as allowed for FIP pursuant to 441—subrule 41.27(2) for a non-home based enterprise.

2. In determining net profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the costs allowed for FIP pursuant to 441—subrule 41.27(2) will be allowed except deductions are limited to 10 percent of the total gross income to cover the costs of upkeep for the home.

(4) When the client is renting out apartments in the client's home, the following will be deducted from the gross rentals received to determine the profit:

1. Shelter expense in excess of that set forth on the chart of basic needs components for FIP in 441—subrule 41.28(2).

2. That portion of expense for utilities furnished to tenants that exceeds the amount set forth on the chart of basic needs components for FIP in 441—subrule 41.28(2).

3. Ten percent of gross rentals to cover the cost of upkeep.

(5) In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts will be deducted from the payments received:

1. $41 plus an amount equivalent to the monthly maximum Supplemental Nutrition Assistance Program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

2. Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

(6) Gross income from providing child care in the applicant's or member's own home will include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 as amended to August 1, 2025, for the cost of providing meals to children.

1. In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received will be deducted to cover the costs of producing the income unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

2. When the applicant or member requests to have expenses in excess of the 40 percent considered, profit will be determined in the same manner as specified at numbered paragraph 75.8(6)*"a"*(3)"2."

(7) Unearned income. Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contributions Act as amended to August 1, 2025, state and federal income taxes). Net unearned income will be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction will be considered gross income available to meet the needs of the eligible group.

1. Social security income is the amount of the entitlement before withholding of a Medicare premium.

2. When the client sells property on contract, proceeds from the sale will be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined for FIP in 441—subrule 41.26(4). The interest portion of the payment is considered a resource the month following the month of receipt.

3. Support payments in cash will be considered as unearned income in determining initial and continuing eligibility.

- Any nonexempt cash support payment for a member of the eligible group made while the application is pending will be treated as unearned income.
- Support payments will be considered as unearned income in the month in which the IV-A agency (the department's income maintenance area) is notified of the payment by the IV-D agency (child support services). The amount of income to consider will be the actual amount paid or the monthly entitlement, whichever is less.
- Support payments reported by child support services during a past month for which eligibility is being determined will be used to determine eligibility for the month. Support payments anticipated to be received in future months will be used to determine eligibility for future months. When support payments terminate in the month of decision of a family-related application, both support payments already received and support payments anticipated to be received in the month of decision will be used to determine eligibility for that month.

(8) Income will be diverted to meet the unmet needs of ineligible children and to permit payment of court-ordered support to children not living with the parent as allowed for FIP pursuant to 441—subrule 41.27(4).

(9) The following FIP policies also apply to determining income eligibility for family-related medically needy: 441—subrules 41.27(3), 41.27(5), 41.27(6), 41.27(7), and 41.27(8) and 441—paragraphs 41.27(9)*"c," "g," "h,"* and *"i."*

b. Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

c. The monthly income will be determined prospectively unless actual income is available.

d. The income for the certification period will be determined by adding both months' net income together to arrive at a total.

e. The income for the retroactive certification period when applicable pursuant to 441—subrule 76.13(3) will be determined by adding each month of the retroactive period to arrive at a total.

75.8(7) *Medically needy income level (MNIL).*

a. The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided for FIP in 441—subrule 41.28(2) with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	$483	$483	$566	$666	$733	$816	$891	$975	$1058	$1158

Each additional person $116

b. When determining household size for the MNIL, all potentially eligibles and all individuals whose income is considered as specified in subrule 75.8(4) shall be included unless the person has been excluded according to the provisions of paragraph 75.8(4)*"d."*

c. The MNIL for the certification period will be determined by adding both months' MNIL to arrive at a total. The MNIL for the retroactive certification period when applicable pursuant to 441—subrule 76.13(3) will be determined by adding each month of the retroactive period to arrive at a total.

d. The total net countable income for the certification period will be compared to the total MNIL for the certification period based on family size as specified in paragraph 75.8(7)*"b."* If the total countable net income is equal to or less than the total MNIL, the medically needy individuals will be eligible for Medicaid. If the total countable net income exceeds the total MNIL, the medically needy individuals will

not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

e. Effective date of approval. Eligibility during the certification period, or the retroactive certification period when applicable pursuant to 441—subrule 76.13(3), will be effective as of the first day of the first month of the certification period or the retroactive certification period when the MNIL is met.

75.8(8) *Verification of medical expenses to be used in spenddown calculation.* The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider.

a. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to Iowa Medicaid on a claim form. The applicant or member shall inform the provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the worker will obtain the claim form from the provider.

b. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) will be on forms specified by the department. Applicants who have not established that they met spenddown in the current certification period will be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

75.8(9) *Spenddown calculation.*

a. Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period will be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met:

(1) The expenses remain unpaid as of the first day of the certification period.

(2) The expenses are not Medicaid-payable in a previous certification period or the retroactive certification period when applicable pursuant to 441—subrule 76.13(3).

(3) The expenses are not incurred during any prior certification period with the exception of the retroactive period, when applicable pursuant to 441—subrule 76.13(3), in which the person was conditionally eligible but did not meet spenddown.

(4) Notwithstanding subparagraphs 75.8(9)*"a"*(1) through *"a"*(3), paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

b. Spenddown will be adjusted under the following circumstances:

(1) When a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received.

(2) When a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service.

(3) When an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

c. Order of deduction. Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid but excluding those otherwise subject to payment by a third party, will be deducted in the following order:

(1) Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health

insurance premium will not be allowed as a deduction to meet the spenddown obligation of household members in the medically needy coverage group.

(2) An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility will be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication. The average statewide monthly standard deduction for personal care services will be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed by multiplying the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the consumer price index for all urban Consumers as published by the United States Bureau of Labor Statistics.

(3) Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

(4) Medical expenses for acupuncture, chronologically by date of submission.

(5) Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

d. When spenddown has been met and a bill is received with a service date after spenddown has been met, the bill will not be deducted to meet spenddown.

e. When incurred medical expenses have reduced income to the applicable MNIL, the individuals will be eligible for Medicaid.

f. Medical expenses reimbursed by a public program other than Medicaid prior to the certification period will not be considered a medical deduction.

75.8(10) *Medicaid services.* Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

a. Care in a nursing facility or an ICF-ID.

b. Care in an institution for mental disease.

c. Care in a Medicare-certified skilled nursing facility.

75.8(11) *Reviews.* Reviews of eligibility will be made for SSI-related and family-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance will the period of time between reviews exceed 12 months. Family-related medically needy persons and SSI-related needy persons shall complete forms specified by the department as part of the review process when requested to do so by the department.

75.8(12) *Redetermination.* When an SSI-related or family-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility will be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination will be effective the month the income exceeds the MNIL or the first month following timely notice.

a. The department will determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

b. All eligibility factors will be reviewed on redeterminations of eligibility.

75.8(13) *Recertifications.* A new application must be submitted when the certification period has expired and there has been a break in assistance as defined at subrule 75.8(1). When the certification period has expired and there has not been a break in assistance, the family-related members and SSI-related members shall use forms specified by the department to be recertified.

75.8(14) *Disability determinations.* An applicant receiving social security disability benefits under Title II of the Act or railroad retirement benefits based on the Act's definition of disability by the Railroad Retirement Board will be deemed disabled without any further determination. In other cases under the medically needy program, the department will conduct an independent determination of disability unless the applicant has been denied SSI benefits based on lack of disability and the applicant does not allege

either (1) a disabling condition different from or in addition to that considered by the SSA or (2) that the applicant's condition has changed or deteriorated since the most recent SSA determination.

a. In conducting an independent determination of disability, the department will use the same criteria required by federal law to be used by the SSA in determining disability for purposes of SSI under Title XVI of the Act. The disability determination services division of Iowa workforce development will make the initial disability determination on behalf of the department.

b. For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign, and submit forms as specified by the department.

c. In connection with any independent determination of disability, the department will determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms specified by the department as required in paragraph 75.8(14)*"b."*

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.9(249A) Furnishing of social security number.

75.9(1) *Requirement.* As a condition of eligibility, except as provided by subrule 75.9(2), a Medicaid client must provide to the department all social security numbers issued to each individual (including children) for whom Medicaid is sought.

75.9(2) *Exceptions to requirement.* The requirement of subrule 75.9(1) does not apply to an individual who:

a. Is not eligible to receive a social security number;

b. Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR §422.104; or

c. Refuses to obtain a social security number because of a well-established religious objection. For this purpose, a well-established religious objection means that the individual:

(1) Is a member of a recognized religious sect or division of the sect; and

(2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

75.9(3) *Cooperation in obtaining social security number.* If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the SSA or in requesting the SSA to furnish the number.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) *Definitions.* The following definitions apply for the purposes of this subrule:

a. Institution. "Institution" means an "institution" or a "medical institution" as those terms are defined in 42 CFR §435.1010. For purposes of state placement, "institution" also includes foster care homes licensed as set forth in 45 CFR §1355.20 and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

b. Incapable of expressing intent regarding residency. For purposes of this rule, an individual is considered to be "incapable of indicating intent regarding residency" if the individual:

(1) Has an IQ of 49 or less or has a mental age of seven or less;

(2) Has been judged legally incompetent; or

(3) Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

c. Iowa resident. An Iowa resident is one:

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

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

75.10(2) *Determination of residency.* State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual's residency.

a. Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care maintenance payments or have a guardianship assistance agreement or have an adoption assistance agreement under Title IV-E of the Act are considered to be residents of the state where the child lives.

b. Cases of disputed residency. If two or more states do not agree on an individual's state of residence, the state where the individual is physically located is the state of residence.

c. Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to that state when the purpose of the absence has been accomplished remains a resident of that state during the absence unless another state has determined that the person is a resident there for Medicaid purposes.

d. Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual's state of residence during that placement.

(1) Any action beyond providing information to the individual and the individual's family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

1. Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and providing facilities in another state.

2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

(2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual's state of residence is the state where the individual is physically located.

e. Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. §1382e (including payments from Iowa pursuant to 441—Chapters 50 through 54 and Chapter 177) are considered to be residents of the state paying the supplementary assistance.

f. Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is capable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

g. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

h. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

i. Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

j. Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is capable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

(1) Intends to reside, with or without a fixed address; or

(2) Entered with a job commitment or to seek employment, whether or not currently employed.

k. Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

l. Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is capable of indicating intent regarding residency and who is married or emancipated from the individual's parent, the state of residence is determined in accordance with paragraph 75.10(2)*"j."*

m. Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2)*"k"* or *"l,"* the state of residence is:

(1) The state where the individual resides, with or without a fixed address; or

(2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2)*"j,"* with whom the individual resides.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) *Definitions.* For purposes of this rule, the following definitions apply.

"Care and services necessary for the treatment of an emergency medical condition" means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services will be limited to medical services that are required and directly related to the treatment of the emergency medical condition.

"Citizen" and *"citizenship"* includes both citizens of the United States and nationals of the United States as defined in 8 U.S.C. §1101(a)(22).

"Federal means-tested program" means all federal programs that are means-tested, with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.

2. Short-term, non-cash, in-kind emergency disaster relief.

3. Assistance or benefits under the National School Lunch Act as amended to August 1, 2025.

4. Assistance or benefits under the Child Nutrition Act of 1966 as amended to August 1, 2025.

5. Public health assistance (not including any assistance under Title XIX of the Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.

6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part but only if the foster or adoptive parent (or parents) of the child is a qualified alien as defined in Section 431 of the Act.

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965 as amended to August 1, 2025, and Titles III, VII, and VIII of the Public Health Services Act as amended to August 1, 2025.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965 as amended to August 1, 2025.

10. Benefits under the Head Start Act, as amended to August 1, 2025.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"INA" means the Immigration and Naturalization Act as amended to August 1, 2025, unless another effective date is specified.

"Noncitizen" means the same as "alien" as defined in 8 U.S.C. §1101(a)(3).

"Qualified noncitizen" means the same as "qualified alien" as defined in 8 U.S.C. §1641(b) and (c). A qualified noncitizen is:

1. Lawfully admitted for permanent residence in the United States under the INA;
2. Granted asylum in the United States under Section 208 of the INA;
3. A refugee admitted to the United States under Section 207 of the INA;
4. Paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. An individual whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA;
6. Granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. An Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);
8. A Cuban/Haitian entrant to the United States as described in Section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422) as amended to August 1, 2025;
9. A battered noncitizen as described in 8 U.S.C. Section 1641(c);
10. Certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to August 1, 2025;
11. An American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e) as amended to August 1, 2025;
12. Under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii); or
13. Lawfully residing in the United States in accordance with a Compact of Free Association with the Government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of Public Law 116-260 and as amended to August 1, 2025.

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Act worked by a parent of a noncitizen while the noncitizen was under the age of 18 and all of the

qualifying quarters worked by a spouse of the noncitizen during their marriage if the noncitizen remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Act for any period beginning after December 31, 1996, may be credited to a noncitizen if the parent or spouse of the noncitizen received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. Eligibility. To be eligible for Medicaid, a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified noncitizen continuously present (as described in Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) at 62 FR 61415 dated November 11, 1997, and as amended to August 1, 2025) in the United States since before August 22, 1996.

(3) A qualified noncitizen under the age of 21.

(4) A refugee admitted to the United States under Section 207 of the INA.

(5) A noncitizen who has been granted asylum under Section 208 of the INA.

(6) A noncitizen whose deportation is withheld under Section 243(h) or 241(b)(3) of the INA.

(7) A qualified noncitizen veteran who has an honorable discharge that is not due to alienage.

(8) A qualified noncitizen who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified noncitizen who is the spouse or unmarried dependent child of a qualified noncitizen described in subparagraph 75.11(2)*"a"*(7) or *"a"*(8), including a surviving spouse who has not remarried.

(10) A qualified noncitizen who has resided in the United States for a period of at least five years beginning on the date of the qualified noncitizen's entry into the United States with a status within the meaning of numbered paragraph "1," "4," or "9" under the definition of "qualified noncitizen" in subrule 75.11(1).

(11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).

(12) A Cuban/Haitian entrant as described in Section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422) as amended to August 1, 2025.

(13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to August 1, 2025.

(14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e) as amended to August 1, 2025.

(15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to August 1, 2025, or to Section 602(b)(8) of Public Law 111-8 as amended to August 1, 2025.

(16) An Afghan paroled into the United States treated as a refugee pursuant to Section 2502 of Public Law 117-43 as amended to August 1, 2025.

(17) A qualified noncitizen lawfully residing in the United States in accordance with a Compact of Free Association with the Government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of Public Law 116-260 and as amended to August 1, 2025.

(18) A conditional entrant pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980.

b. Attestation of citizenship or qualified noncitizen status. As a condition of eligibility, each applicant and member shall attest in writing to the applicant's or member's citizenship or qualified noncitizen status by signing the applicable form identified in subparagraph 75.11(2)*"b"*(1), *"b"*(2), *"b"*(3), or *"b"*(4). The attestation may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative as defined in rule 441—76.1(249A), or, if the individual is a minor or incapacitated, by someone acting responsibly for the individual provided the person acting responsibly attests to having knowledge of the individual's status.

(1) All applicants for Medicaid shall attest to their citizenship or qualified noncitizen status by signing forms prescribed by the department that contain the declaration of their citizenship or qualified noncitizen status.

(2) Family-related Medicaid members and members subject to MAGI methodology shall attest to their citizenship or qualified noncitizen status by completing and signing forms prescribed by the department that contain the declaration of their citizenship or qualified noncitizen status.

(3) Non-MAGI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or qualified noncitizen status by signing the application form described in subparagraph 75.11(2)*"b"*(1) at time of review.

(4) The department will prescribe forms for an attestation of citizenship or qualified noncitizen status that will meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to rule 441—76.4(249A).

c. Verification of citizenship and identity or qualified noncitizen status. An applicant or member attestation of citizenship or qualified noncitizen status must be verified as a condition of eligibility for Medicaid. An applicant or member who attests to citizenship must also verify their identity. The verification of citizenship status is acceptable as identity verification, except as stated otherwise within this subrule.

(1) Verification by electronic data sources. The department will accept applicant or member attestation of citizenship or qualified noncitizen status as verified when the attestation is consistent with available EDS.

(2) Satisfactory documentation of citizenship and identity is required. Except for the persons identified in paragraph 75.11(2)*"i,"* applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph 75.11(2)*"b"* shall present satisfactory documentation of the attested status and their identity when the attestation is not verified by available electronic data sources. Satisfactory documentation is identified in paragraphs 75.11(2)*"d," "e," "f," "g,"* and *"h."* The provisions of the reasonable opportunity period described in subparagraphs 75.11(2)*"c"*(4) and *"c"*(5) apply.

(3) Satisfactory documentation of qualified noncitizen status is required. Except for persons receiving SSI benefits under Title XVI of the Act, applicants or members for whom an attestation of a qualified noncitizen status has been made pursuant to paragraph 75.11(2)*"b"* shall present satisfactory documentation of the attested status when the attestation is not verified by available EDS. Satisfactory documentation of qualified noncitizen status is identified in paragraph 75.11(2)*"j."* The department will request documentation in writing from the applicant or member. The provisions of the reasonable opportunity period described in subparagraphs 75.11(2)*"c"*(4) and *"c"*(5) applies.

(4) Reasonable opportunity period for providing satisfactory documentation. Applicants and members will be allowed a reasonable opportunity period of 90 days to provide satisfactory documentation of citizenship and identity or qualified noncitizen status. The reasonable opportunity period begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2)*"c"*(3) or *"c"*(7) above is issued to an applicant or member, whichever is later, and continues for 90 days.

(5) Medicaid approval pending reasonable opportunity period. Medicaid will be approved for new applicants and continue for members not previously required to provide documentation of citizenship and identity or qualified noncitizen status until the end of the reasonable opportunity period, subject to 441—subrule 76.16(1).

(6) No retroactive eligibility until citizenship and identity or qualified noncitizen status is verified. Retroactive eligibility pursuant to 441—subrule 76.13(3) is available only after citizenship and identity or qualified noncitizen status has been verified with EDS or documentation has been provided pursuant to paragraph 75.11(2)*"d," "e," "f," "g," "h,"* or *"j."* When applicable, the retroactive months are outside the reasonable opportunity period during which Medicaid coverage may be provided without required documentation of citizenship and identity or qualified noncitizen status.

(7) Verification of citizenship and identity or qualified noncitizen status not required. Applicants who reapply following a break in coverage and members who are subject to an eligibility review are not required to reverify citizenship and identity or qualified noncitizen status unless:

1. The individual reports a change in citizenship or qualified noncitizen status;

2. The individual's qualified noncitizen status is a type the department has determined is subject to change; or

3. The department receives information indicating a potential change in the individual's citizenship or qualified noncitizen status.

d. Standalone evidence of citizenship and identity. Any one of the documents described in 42 CFR 435.407(a) will be accepted as sufficient evidence of citizenship and identity. In addition, provision of an individual's name, social security number, and date of birth to the department will constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the SSA produces a data match response that substantiates the individual's citizenship and identity. If submission of the name, social security number, and date of birth to the SSA does not produce a data match response that substantiates the individual's citizenship and identity, the department will issue a written request for documentation or a notice to the applicant or member pursuant to subparagraph 75.11(2)*"c"*(4) giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted; to correct any errors in the SSA's records; or to provide other documentation of citizenship and identity pursuant to paragraphs 75.11(2)*"d"* through *"h."*

e. Combination evidence of citizenship.

(1) If an applicant does not provide documentary evidence of citizenship and identity from the list in paragraph 75.11(2)*"d,"* information or documentation as described in 42 CFR 435.407(b) will be accepted as satisfactory evidence to establish citizenship if accompanied by an identity document listed in paragraph 75.11(2)*"f"*:

(2) If the applicant does not have one of the documents listed in paragraph 75.11(2)*"d"* or *"e,"* they may submit an affidavit provided by the department, signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

f. Evidence of identity. Any of the following documents described in 42 CFR 435.407(c) or (d) will be accepted as proof of identify, provided the document has a photograph or other identifying information sufficient to establish identity, including but not limited to name, age, sex, race, height, weight, eye color, or address.

g. Reserved.

h. Documentary evidence. The department will accept documents in accordance with 42 CFR 435.407(f) and provide assistance in a timely manner to individuals who need assistance in securing satisfactory documentary evidence of citizenship or identity in accordance with 42 CFR 435.407(e).

i. Persons not required to verify citizenship and identity status. A person for whom an attestation of United States citizenship has been made pursuant to paragraph 75.11(2)*"b"* is not required to present documentation of citizenship and identity for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving SSI benefits under Title XVI of the Act.

(4) The person is or was exempted while assisted by child welfare services funded under Part B of Title IV of the Act on the basis of being a child in foster care as defined in Iowa Code section 232.2. This exemption does not apply and the person is subject to the citizenship and identity documentation requirements described in paragraph 75.11(2)*"c"* when services under Part B of Title IV were terminated due to failure to meet citizenship requirements.

(5) The person is or was exempted while assisted by foster care as defined in Iowa Code section 232.2 or adoption assistance funded under Part E of Title IV of the Act. This exemption does not apply and the person is subject to the citizenship and identity documentation requirements described in paragraph 75.11(2)*"c"* when services under Part E of Title IV were terminated due to failure to meet citizenship requirements.

(6) The person has previously presented satisfactory documentary evidence of citizenship and identity as specified by the United States Secretary of Health and Human Services.

(7) The person is or was deemed eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) on or after July 1, 2006, as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Act.

j. Satisfactory documentation of qualified noncitizen status. For the purpose of subparagraph 75.11(2)*"c"*(3), satisfactory documentation of qualified noncitizen status is documentation issued by the U.S. Citizenship and Immigration Services (USCIS) of the Department of Homeland Security (formerly Immigration and Naturalization Service (INS)) that identifies the person's qualified noncitizen status.

75.11(3) *Deeming of sponsor's income and resources.* When a qualified noncitizen admitted for lawful permanent residence (including those who applied for an immigrant visa or for adjustment of status, other than those whose status was adjusted from refugee or asylee status under 8 U.S.C. §1159 on or after December 19, 1997) is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the qualified noncitizen, the income and resources of each sponsor will be deemed to determine eligibility only for the sponsored qualified noncitizen and not for any nonsponsored members of the sponsored qualified noncitizen's household as follows:

a. Income. For the family-related and non-MAGI-related coverage groups described in rules 441—75.3(249A) through 441—75.9(249A) applicable to the sponsored qualified noncitizen, the amount deemed to the sponsored qualified noncitizen will be the total gross countable income of each sponsor less the following deductions that will be applied to both family-related and non-MAGI-related applicants or members:

(1) The deductions described at 20 CFR §416.1166a, except that the amount to be deemed from each sponsor will be divided by the number of noncitizens sponsored by that sponsor.

(2) Diversion from countable earned and unearned income of the sponsor for the following:

1. Alimony or child support payments to persons not living with the sponsor.

2. Payments made to persons not living with the sponsor but who are claimed (or could be claimed) by the sponsor for federal income tax purposes.

b. Resources for non-MAGI-related coverage groups. When the sponsored qualified noncitizen's coverage group is non-MAGI-related, the total gross countable resources of each sponsor will be deemed to determine eligibility of the sponsored qualified noncitizen pursuant to 20 CFR §416.1204 less the applicable following deduction: $2,000 if the sponsor does not live with a spouse, $3,000 if the sponsor lives with a spouse who is not a sponsor, or $4,000 if the sponsor lives with a spouse who is also the qualified noncitizen's sponsor. Resources are not considered for family-related coverage groups and therefore not deemed to a sponsored qualified noncitizen applying for or receiving under a family-related coverage group.

c. An indigent qualified noncitizen is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. A qualified noncitizen will be considered indigent if the following are true:

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

(2) The qualified noncitizen's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the FPL for the sponsored qualified noncitizen's household size.

d. A battered qualified noncitizen as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income and resources for 12 months.

e. Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored qualified noncitizen attains citizenship through naturalization pursuant to Chapter 2 of Title II of the INA as amended to August 1, 2025.

(2) The sponsored qualified noncitizen has earned 40 qualifying quarters of coverage as defined in Title II of the Act or can be credited with 40 qualifying quarters as defined in subrule 75.11(1).

(3) The sponsored qualified noncitizen or the sponsor dies.

(4) The sponsored qualified noncitizen is a lawfully residing child under the age of 21 as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

(5) For non-MAGI-related Medicaid, the sponsored qualified noncitizen becomes blind or disabled as defined under Title XVI of the Act after admission to the United States as a lawful permanent resident.

(6) For non-MAGI-related Medicaid, three years after the date the sponsored qualified noncitizen was admitted to the United States as a lawful permanent resident.

75.11(4) *Eligibility for payment of emergency medical services.* Noncitizens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their noncitizen status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision, the noncitizen must meet all other eligibility criteria, including state residence requirements in rule 441—75.10(249A), with the exception of rule 441—75.9(249A) and subrules 75.11(2) and 75.11(3).

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, "inmate of a public institution" and "public institution" mean the same as defined in 42 CFR Section 435.1010.

75.12(1) *Suspension.* Medical assistance will be suspended rather than canceled while a person is an inmate of a public institution if all of the following conditions are met:

a. The department is notified of the person's entry into the public institution through either:

(1) A daily report that is provided to the department by the public institution and includes the person's first name and last name and the date the person entered the institution; or

(2) Other verified notice received by the department.

b. The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.

c. On the date of entry into the public institution, the person was a Medicaid member.

d. The person is eligible for medical assistance as an individual except for institutional status.

75.12(2) *Coverage during suspension.* While medical assistance is suspended, payment will be made only for services limited to inpatient hospital claims only.

75.12(3) *Reinstatement.* The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:

a. The department is notified of the person's release from the public institution through either:

(1) A daily report provided to the department by the public institution that includes the person's first name and last name and the date the person was released from the institution; or

(2) Other verified notice received by the department.

b. All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.13 Reserved.

441—75.14(249A) Establishing liability and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested or received and for whom the applicant or member can legally assign rights for medical support, except when the member has good cause for refusal to cooperate as defined in subrule 75.14(7).

a. The adult applicant shall agree to cooperate in obtaining medical support at the time of application.

b. The adult member shall cooperate in the following:

(1) Identifying and locating parties liable for the support of household members receiving Medicaid.

(2) Establishing liability for the support of household members receiving Medicaid, including establishment of paternity if paternity has not previously been established.

(3) Obtaining medical support and payments for medical care for household members receiving Medicaid.

c. Cooperation is defined as including the following actions by the adult member upon request:

(1) Appearing at the child support services as defined in 441—Chapter 95 to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the member that is relevant to achieving the objectives of the child support recovery program.

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

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

d. Upon request, the adult member shall cooperate with the department in supplying information with respect to potentially liable parties, the receipt of medical support or payments for medical care, and the establishment of liability for support to the extent necessary to establish eligibility for assistance.

e. Upon request, the adult member shall cooperate with child support services by supplying all known information and documents pertaining to the location of potentially liable parties and taking action as may be necessary to secure medical support and payments for medical care or to establish liability. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

f. Child support services will make the determination of whether or not the adult member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant to agree to cooperate or an adult member to cooperate will result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family-related Medicaid cases, all exclusions, expenses and deductions described in rule 441—75.73(249A) will be allowed when otherwise applicable.

75.14(3) Each Medicaid member who is required to cooperate with child support services shall have the opportunity to claim good cause for refusing to cooperate in establishing liability or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(7) through 75.14(11) will be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the member's own behalf or on behalf of any other person in the household who receives Medicaid.

An assignment is effective the same date the notice of eligibility is issued and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support will not be assigned to the department.

75.14(5) Pregnant women establishing eligibility under the MAC coverage group as provided in subrule 75.3(2) will be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.3(4) will not be subject to the provisions in this rule until after the end of the month in which the postpartum period expires.

Pregnant women establishing eligibility under any other coverage groups, except those set forth in subrule 75.3(2) or 75.3(4), will be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman will lose eligibility under her current coverage group and her eligibility for Medicaid will be automatically redetermined under subrule 75.3(2).

75.14(6) Notwithstanding subrule 75.14(5), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.3(2) or 75.3(4) will not be exempt from the provisions of 75.14(4) that require an adult member to assign any rights to medical support and payments for medical care.

75.14(7) Good cause exists when it is determined that cooperation in establishing liability and securing support is against the best interests of the child.

a. The department will determine that cooperation is against the child's best interest when the member's cooperation in establishing liability or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought;

(2) Physical or emotional harm to the parent or other caretaker with whom the child is living that reduces the person's capacity to care for the child adequately.

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

(1) The child was conceived as the result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption and the discussions have not gone on for more than three months.

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

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

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

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

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the liability establishment or support enforcement activity to be undertaken.

75.14(8) Each Medicaid member who is required to cooperate with child support services will have the opportunity to claim good cause for refusing to cooperate in establishing liability or securing support payments.

a. Before requiring cooperation, the department will notify the member of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause will:

(1) Advise the member of the potential benefits the child may derive from the establishment of liability and securing support.

(2) Advise the member that by law cooperation in establishing liability and securing support is a condition of eligibility for the Medicaid program.

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

(4) Advise the member that good cause for refusal to cooperate may be claimed and that if the department determines, in accordance with these rules, that there is good cause, the member will be excused from the cooperation requirement.

(5) Advise the member that upon request, or following a claim of good cause, the department will provide further notice with additional details concerning good cause.

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

(1) Indicates that the member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the member that, upon request, the department will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the member that on the basis of the corroborative evidence supplied and the department's investigation, when necessary, the department will determine whether cooperation would be against the best interests of the child for whom support would be sought.

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

(5) Informs the member that child support recovery services may review the findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the member that child support recovery services may attempt to establish liability and collect support in those cases where it is determined that this can be done without risk to the member if done without the member's participation.

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

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

(2) Corroborate the good cause circumstances.

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

75.14(9) The department will determine whether good cause exists for each Medicaid member who claims to have good cause.

a. The department will notify the member of its determination that good cause does or does not exist. The determination will:

(1) Be in writing.

(2) Contain the findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether good cause exists will be made within 45 days from the day the good cause claim is made. The department may exceed this time standard only when:

(1) The case record documents that the department needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(10).

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

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

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The department will make a good cause determination based on the corroborative evidence supplied by the member only after it has examined the evidence and found that it verifies the good cause claim.

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

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

(2) Consider any recommendation from child support services.

f. Child support services may participate in any appeal hearing that results from a member's appeal of a department action with respect to a decision on a claim of good cause.

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

h. The department will:

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

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

75.14(10) The member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the department determines that the member requires additional time because of the difficulty in obtaining the corroborative evidence, the department will allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records that indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records that indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records that indicate that the potentially liable person might inflict physical or emotional harm on the child.

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

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

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

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

(1) Promptly notify the member that additional corroborative evidence is needed, and

(2) Specify the type of corroborative evidence needed.

c. When the member requests assistance in securing evidence, the department will:

(1) Advise the member how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents that the member is not reasonably able to obtain without assistance.

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

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

(2) Good cause will be found when the claimant's statement and investigation satisfies the department that the member has good cause for refusing to cooperate.

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

e. The department may further verify the good cause claim when the member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the department determines that it is necessary, the department may conduct an investigation of good cause claims to determine whether good cause exists.

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

(1) Contact the potentially liable person from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the member so the member may present additional corroborative evidence or information so that contact with the potentially liable person becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(11) Enforcement without parent or other caretaker's cooperation. When the department makes a determination that good cause exists, the department will also make a determination of whether child support services can proceed without risk of harm to the child, parent, or other caretaker when the enforcement or collection activities do not involve their participation.

a. Child support services will have an opportunity to review and comment on the findings and basis for the proposed determination and the department will consider any recommendations from child support services.

b. The determination will be in writing, contain the department's findings and basis for the determination, and be entered into the case record.

c. When the department excuses cooperation but determines that child support services may proceed to establish liability or enforce support, the department will notify the member to enable the individual to have the case closed.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.15(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, services received through Title XVIII of the Act (Medicare), and other resources for meeting the cost of medical care that may be available to the member. These resources must be used when reasonably available.

75.15(1) The department will approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.1(249A) are applicable.

75.15(2) As a condition of eligibility for Medicaid, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department all rights to payments of medical care from any third party to the extent that payment has been made under the Medicaid program. The applicant's signature on the application form listed in 441—paragraph 76.2(1)*"c"* shall constitute agreement to the assignment. The assignment shall be effective for the entire period during which Medicaid makes payment for medical care.

b. Cooperate with the department in obtaining third-party payments. The member or someone acting on the member's behalf shall:

(1) File a claim or submit an application for any reasonably available medical resource, and

(2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the Medicaid program.

75.15(3) Good cause for failure to cooperate in the filing or processing of a claim or application will be considered to exist when the member, or someone acting on behalf of a minor or legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause will be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the member for whom medical resources are being sought;

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor or legally incompetent adult member, for whom medical resources are being sought.

75.15(4) Failure to cooperate as required in subrule 75.15(2) without good cause as defined in subrule 75.15(3) will result in the termination of Medicaid benefits. The department will make the determination of good cause based on information and evidence provided by the member or by someone acting on the member's behalf.

a. The Medicaid benefits of a minor or legally incompetent adult member will not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the Medicaid benefits of the parent or payee will be terminated.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.54.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.16(249A) Medical assistance lien.

75.16(1) When the Medicaid program pays for a member's medical care or expenses, the department will have a lien upon all monetary claims that the member may have against third parties for those

expenses. Monetary claims will include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien will be to the extent of the Medicaid payments only.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for Medicaid is established. The notice of lien will be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including but not limited to notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member that fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications required by law shall be directed to the department. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.16(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this rule, upon the receipt of the judgment or settlement of the total claim, of which the lien for Medicaid payments is a part, the court costs and reasonable attorney fees will first be deducted from this total judgment or settlement. One-third of the remaining balance will then be deducted and paid to the member. From the remaining balance, the lien of the department will be paid. Any amount remaining will be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees that is in excess of the amount the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.16(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or someone acting on the member's behalf, Medicaid benefits will be terminated. The Medicaid benefits of a minor child or a legally incompetent adult member will not be terminated under this subrule. Subsequent eligibility for Medicaid benefits will be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense will not be paid by the Medicaid program.

a. The member, or someone acting on the member's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. The member or person acting on the member's behalf shall complete a form prescribed by the department, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved. A report will be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Act (Medicare) and other resources.

(3) The date the member, or someone acting on the member's behalf, files an insurance claim against an insured third party for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or someone acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or someone acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid. The member may report the change in person, by telephone, by mail, or by using forms prescribed by the department when annual reviews are completed and when the client requests a form.

c. The member, or someone acting on the member's behalf, shall complete a form prescribed by the department when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form or in giving complete and accurate information will result in the termination of Medicaid benefits.

d. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee will be terminated. When a parent or payee fails to cooperate in completing or returning any form required by the department, or fails to give complete and accurate information concerning the accident-related injuries of a minor legally incompetent adult member, the department will terminate the Medicaid benefits of the parent or payee.

e. The member, or someone acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so will result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee will be terminated.

75.16(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on Form CMS-1500 that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for Medicaid or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.16(1). The mailing and deposit in a U.S. post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.16(5) *Department's lien.*

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving Medicaid from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice. Any information released to an attorney, insurer or other third party by the health care services provider that indicates that reimbursement from the state was contemplated or received will be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider that indicates Medicaid involvement will be construed as showing involvement by the department under Iowa Code section 249A.54. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department will issue notice to that attorney of the department's lien rights.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department will issue notice to the insurer of the department's lien rights.

d. The mailing and deposit in a U.S. post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.16(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency that is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for Medicaid or a past or present Medicaid member.

75.16(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.54.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.17 Reserved.

441—75.18(249A) Continuous eligibility for pregnant women.

75.18(1) A pregnant woman who was eligible and enrolled in Medicaid under the provisions of this chapter prior to the end of her pregnancy shall remain continuously eligible throughout the pregnancy and the 12-month postpartum period as provided in subrule 75.3(4), regardless of changes in circumstances, except if any of the following occur:

a. The woman requests voluntary termination of eligibility.

b. The woman ceases to be a resident of the state of Iowa.

c. Iowa Medicaid finds that the woman's eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury.

d. The woman dies.

75.18(2) Except as described in subrule 75.3(4), the woman is not required to meet any eligibility criteria described in this chapter or the reenrollment requirements at 441—paragraph 76.14(1)*"a"* during the pregnancy and 12-month postpartum period.

75.18(3) At the end of the 12-month postpartum period, the woman will be subject to the reenrollment requirements at 441—paragraph 76.14(1)*"b."*

75.18(4) Pregnant women determined eligible only for emergency services pursuant to subrule 75.11(4) are eligible under this provision.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid will retain that eligibility for up to 12 months regardless of changes in family circumstances, except as described in this rule.

75.19(1) *Exceptions to coverage.* This rule does not apply to the following:

a. Children whose eligibility was determined under the newborn coverage group described in subrule 75.3(3).

b. Children whose eligibility was determined under the medically needy coverage group described in rule 441—75.8(249A).

c. Children whose Medicaid is state-funded only.

d. Children eligible only in a retroactive month pursuant to 441—subrule 76.13(3).

e. Children whose U.S. citizenship and identity, or noncitizenship status, is not verified within the reasonable opportunity period described in paragraph 75.11(2)*"c."*

f. Children whose eligibility was determined under express lane procedures described in rule 441—76.4(249A).

g. Children whose initial eligibility was established incorrectly.

75.19(2) *Duration of coverage.* Coverage under this rule will extend through the earliest of the following:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19, except as stated in rule 441—75.52(249A);

c. The month when the child ceases to be a resident of Iowa or fails to provide the department with adequate information to determine whether the child meets residency requirements pursuant to rule 441—75.10(249A);

d. The month that voluntary termination of eligibility is requested; or

e. The month the child is determined to be deceased.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household will be assigned the same annual eligibility review date as that established for the household.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.20(249A) Medical assistance corrective payments. If a decision by the department or SSA following an appeal on a denied application for any of the coverage groups set forth in 441—75.3(249A) through 441—75.8(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular Medicaid coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.20(1) These bills must be for services covered by the Medicaid program as set forth in 441—Chapter 78.

75.20(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.20(3) If a county relief agency has paid medical bills on the member's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the member.

75.20(4) Members and county relief agencies may file claims for payment under this subrule on forms prescribed the department. These forms are available from the county office. All requests for reimbursement will be acted upon within 60 days of receipt of the forms in the county office.

75.20(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 2506.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the HIPP program, the department will pay for the cost of premiums, coinsurance, copayments, and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid, including managed care capitation fees. Payment will include only the cost to the Medicaid-eligible individual or household.

75.21(1) *Definitions.* For purposes of this rule, the following definitions apply:

"Absent parent" means a noncustodial parent or a parent who is not living with the member.

"Authorized representative" means an individual or organization authorized by a competent applicant or member; authorized by a responsible person acting for an incompetent applicant or member pursuant to 441—subrule 76.9(2); or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

"Capitation payment" means a monthly payment to the managed care contractor on behalf of each member for the provision of health services under the managed care organization contract. Payment is made by the department regardless of whether the member receives services during the month. The managed care capitation payment varies based on the eligible member's sex, age, and eligibility aid type.

"Cost-effective" means a determination has been made that a savings will accrue to the department by paying the insurance premium, cost sharing, wrap benefits, and administrative cost.

"Cost sharing" means the member's portions of in-network health care costs not covered by an insurance plan. "Cost sharing" includes copayments, coinsurance and deductibles, which vary among health care plans.

"Custodian" means the person recognized as representing the interests of the member for Medicaid assistance. When the member reaches the age of 18 and the custodian is not used in determining Medicaid eligibility, there shall be legal documentation in place that the custodian is now the responsible person or authorized representative.

"Employer-sponsored insurance" or *"ESI"* means any health insurance plan paid for by a business on behalf of its employees.

"High-deductible health plan" or *"HDHP"* means a health insurance plan that meets the definition found in Section 223(c)(2) of the United States Internal Revenue Code as amended to August 1, 2025.

"HIPP-eligible member" or *"HIPP enrollee"* means a person whose Medicaid eligibility is calculated in the cost-effective determination for HIPP.

"Household" means the group of people who are used in the budgeting and size when determining Medicaid eligibility.

"Individual plan" means an insurance plan purchased through a government-run health insurance marketplace or through a local broker or agent.

"Insurance plan" means major medical comprehensive health coverage provided through an employer, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended to August 1, 2025, a government-run health insurance marketplace, or a local broker or agent. Dental and vision plans are not considered to be insurance plans for purposes of this definition.

"Member" means an individual who has been determined eligible for Medicaid assistance and is enrolled to receive assistance.

"Policyholder" means the person in whose name an insurance policy is registered.

"Responsible person" means an individual recognized by the department pursuant to 441—subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

"Wrap benefits" means the services covered under the Medicaid state plans that are not paid for by insurance plans (i.e., waiver services, transportation).

75.21(2) *Insurance plans.* Participation in an insurance plan is not a condition of Medicaid eligibility. The department will pay for the cost of the insurance plan premiums, coinsurance, copayment, and deductibles of an insurance plan for a member if:

a. A member is enrolled in or can be added to the insurance plan; and

b. The insurance plan is cost-effective as described in subrule 75.21(3).

75.21(3) *Cost-effectiveness.* An insurance plan shall be considered cost-effective when the amount the department would pay for the member's insurance premiums, cost sharing, wrap benefits, and administrative costs is likely to be less than the amount the department would pay through Medicaid, including managed care capitation fees. When determining the cost-effectiveness of an insurance plan, the following data will be considered:

a. The cost to the member or household for the insurance premium, coinsurance, copayments and deductibles. Costs paid by an employer or other plan sponsor will not be considered in the cost-effectiveness determination.

b. The cost of care through Medicaid, including managed care capitation fees, the department would pay for the member.

c. The estimated cost of wrap benefits per member based on the member's sex, age, and eligibility aid type.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire will be used to obtain this information. When the information indicates any health conditions that could be expected to result prospectively in higher-than-average bills for any Medicaid member:

(1) If the member is currently covered by the insurance plan, the department will request from the policyholder, or from the responsible person for the member, an insurance summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the insurance plan. The cost of the insurance plan premium, member's cost sharing, and administrative cost are compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, fee-for-service paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of $150 per HIPP member covered under the health plan.

f. Whether the estimated savings to the department for members covered under the health insurance plan is at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.* When an insurance plan is determined to be cost-effective, the department will pay for insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the insurance plan in order to obtain coverage for the Medicaid-eligible family members. However:

a. The needs of the non-Medicaid-eligible family members will not be taken into consideration when determining cost-effectiveness; and

b. Payments for deductibles, coinsurances or other cost-sharing obligations will not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) *Insurance plans ineligible for reimbursement.* Premiums will not be paid for insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy that supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on the basis of attendance or enrollment at the school.

d. The insurance premium is used to meet a spenddown obligation under the medically needy program, as provided in rule 441—75.8(249A), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium will be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the insurance premium will not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the insurance plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments will be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services.

h. Insurance coverage is provided through the Iowa Comprehensive Health Insurance Association in accordance with Iowa Code chapter 514E.

i. Insurance on the member(s) is maintained by someone who does not live with the member(s), is not the legal guardian of the member(s), is not a responsible person, or does not have legal permission to access the Medicaid information of the member(s) (e.g., self-supporting adult children).

j. The member has Medicare. If other members in the household are covered by the insurance plan, cost-effectiveness is determined without including the Medicare-covered member.

k. The insurance plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

l. The health plan pays secondary to another plan.

m. The only Medicaid member is in foster care.

n. The member is active for Medicaid under Medicaid for children with disabilities (i.e., MKSN) pursuant to subrule 75.6(7). Any other Medicaid members in the household who are covered by the health plan will be determined for cost-effectiveness.

o. The insurance plan is limited due to preexisting conditions.

p. The insurance plan is a subsidized insurance plan purchased through a government-run health insurance exchange.

q. On the date the decision regarding eligibility for the HIPP program is made, the insurance is no longer available.

r. The insurance plan is an HDHP.

75.21(6) *Department evaluation of ESI plans.* When evaluating ESI plans available through an employer, if there is more than one cost-effective insurance plan available, the department will pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan will be determined as follows:

a. Premium payments shall begin the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, HIPP Program Application, or the automated HIPP referral is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the insurance plan when eligibility for participation in the HIPP program is established, premium payments will begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments will not be made for any period of time before the current effective date of coverage.

d. In no case will payments be made for premiums that were used as a deduction to income for determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage will be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage of an insurance plan not obtained through an employer will be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(8) *Method of premium payment.* Payments of premiums will be made directly to the insurance carrier, except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department will reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department will issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage will be made directly to the insurance carrier, the COBRA administrator, or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment; or

(2) The department pays for only part of the total premium.

75.21(9) *Payment of claims.* Claims from medical providers for persons participating in this program will be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(10) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility will be completed annually and may be conducted more frequently at the discretion of the department.

a. Annual review of ESI cost-effectiveness and eligibility will be completed using the HIPP Program Review form.

b. Annual review of individual health plan cost-effectiveness and eligibility will be the HIPP Private Policy Review form.

c. Failure of the household to cooperate in the annual review process will result in cancellation of premium payment.

d. Redeterminations will be completed whenever:

(1) A premium rate, copayment, deductible, or coinsurance changes;

(2) A person covered under the policy loses full Medicaid eligibility;

(3) Changes in employment or hours of employment affect the availability of an insurance plan;

(4) The insurance carrier changes;

(5) The policyholder leaves the Medicaid home;

(6) There is a decrease in the services covered under the policy; or

(7) The Medicaid category of coverage changes.

e. The policyholder shall report changes that may affect the availability of the insurance plan reimbursed by the HIPP program, or changes that affect the cost-effectiveness of the policy, within ten calendar days from the date of the change.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15)*"a,"* will be considered if they are available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department will verify whether coverage may be continued under the provisions of COBRA.

(1) The Employer Verification of COBRA Eligibility form may be used for this purpose.

(2) If it is cost-effective to do so, the department will pay premiums to maintain insurance coverage for members after the occurrence of the event that would otherwise result in termination of coverage.

75.21(11) *Time frames for determining cost-effectiveness.* The department will determine cost-effectiveness of the insurance plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(12) *Notices.*

a. Adequate notice will be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The insurance plan is no longer available to the family (e.g., the employer no longer provides health insurance coverage or the policy is terminated by the insurance company).

b. The department will provide timely and adequate notice as defined in rule 441—16.2(17A) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the insurance plan is no longer cost-effective; or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the HIPP program.

75.21(13) *Rate refund.* The department is entitled to any rate refund made when the insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(14) *Reinstatement of HIPP eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the insurance plan lose Medicaid eligibility, HIPP eligibility will be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the policyholder's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits will be reinstated the first day of the first month in which cooperation occurs if all other eligibility factors are met.

75.21(15) *Amount of insurance premium paid.*

a. For ESI plans, the policyholder shall provide verification of the cost of all possible insurance plan options (i.e., single, employee/children, family).

(1) The HIPP program will pay only for the option that provides coverage to the cost-effective members of the household.

(2) The HIPP program will not pay the portion of the premium cost that is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program will pay the cost of covering the cost-effective members covered by the plan.

c. For insurance plans, if another household member must be covered to obtain coverage for the members, the HIPP program will pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(16) *Reporting changes.* Failure to report and verify changes may result in cancellation of HIPP benefits.

a. The policyholder shall verify changes by providing a pay stub, a summary of benefits and coverage, a rate sheet, or a letter from the insurance carrier reflecting the change.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

d. Any underpayment that results from an unreported change will be paid effective the first day of the month in which the change is reported.

75.21(17) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments will be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department will complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the insurance plan is no longer cost-effective, premium payment will be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility for the HIPP program, the department will discontinue premium payment after timely and adequate notice. The department will request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments will be discontinued pending timely and adequate notice.

e. If the insurance plan is no longer available or the policy has lapsed, premium payments will be discontinued as of the effective date of the termination of the coverage.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" mean the same as defined in Iowa Code section 141A.1.

75.22(1) *Conditions of eligibility.* The department will pay for the cost of continuing health insurance coverage to persons with AIDS or an HIV-related illness when the following criteria are met:

a. The person with AIDS or an HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in rule 441—75.8(249A), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions. When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or an HIV-related illness. The Physician's Verification of Diagnosis form shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the FPL for a family of the same size. The gross income of all family members will be counted using the definition of gross income under the SSI program.

f. Liquid resources shall not exceed $10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

(2) Bank accounts.

(3) Stocks, bonds, and certificates of deposit, excluding IRS-defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) *Application process.*

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV HIPP Application. The applicant shall be required to provide documentation of income and assets. The application will be available from and may be filed at any county office or the department.

An application will be considered as filed on the date an AIDS/HIV HIPP Application containing the applicant's name, address and signature is received and date-stamped in any county office or the department.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, the department will deny pending applications. The department will mail a notice of decision within ten calendar days following the determination that funds have been obligated. The notice will state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants will be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie will be decided by the month of birth, January being month one and the lowest number.

75.22(3) *Presumed eligibility.* The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility will be granted when all of the following occur:

a. The application is accompanied by a completed Physician's Verification of Diagnosis form.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) *Family coverage.* When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness will be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) *Method of premium payment.* Premiums shall be paid in accordance with the provisions of subrule 75.21(8).

75.22(6) *Effective date of premium payment.* Premium payments will be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) *Reviews.* The department will review circumstances of persons participating in the program quarterly to ensure eligibility criteria continue to be met. The AIDS/HIV HIPP Program Review form shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) *Termination of assistance.* Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) *Notices.*

a. An adequate notice as defined in rule 441—16.1(17A) will be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in rule 441—16.2(17A) will be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) *Confidentiality.* The department will protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information form shall be signed by the recipient authorizing the department to make the contact.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) *Ineligibility for services.* When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in subrule 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in subrule 75.23(3). The department will determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When assets were transferred before February 8, 2006, the period of ineligibility begins on the first day of the first month during which the assets were transferred, except as provided in subparagraph 75.23(1)*"a"*(3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph 75.23(1)*"a"*(3), when the assets were transferred on or after February 8, 2006, the period of ineligibility begins on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer will not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in subrule 75.23(3). The department will determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the assets were transferred before February 8, 2006, the period of ineligibility begins on the first day of the first month during which the assets were transferred, except as provided in subparagraph 75.23(1)*"b"*(3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph 75.23(1)*"b"*(3), when the assets were transferred on or after February 8, 2006, the period of ineligibility begins on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer will not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period will not be deducted as medical expenses in determining client participation pursuant to subrule 75.83(2).

75.23(2) *Look-back date.*

a. Transfer before February 8, 2006. When assets were transferred before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. When assets were transferred on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility will be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department will determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. Current average statewide costs will be published on the department's website.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset will be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual will not be ineligible for medical assistance under this rule to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A child of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual that permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship exists only when all of the following conditions are met:

(1) Applying the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources, except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
2. Household goods.
3. A vehicle required by the client for transportation.
4. Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, will be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual that results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility will be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period will be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period will be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* For the purposes of this rule the following definitions apply:

"Assets" includes all income and resources of the individual and the individual's spouse, including any income or resources that the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" means the same as defined in 42 U.S.C. Section 1382a.

"Institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is eligible for home- and community-based waiver services.

"Resources" means the same as defined in 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (subparagraph 75.24(2)*"b"*(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633E.5 on or after July 1, 2000 (Iowa Code section 249A.3(11)*"c"*);

75.23(9) *Purchase of annuities.* Funds used to purchase an annuity for more than its fair market value will be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant will be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9)*"b"* and also meets the condition described in paragraph 75.23(9)*"c."*

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)*"a"* must meet one of the following conditions:

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986 as amended to August 1, 2025 (U.S. IRC).

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the U.S. IRC;
2. A simplified employee pension (within the meaning of Section 408(k) of the U.S. IRC); or
3. A Roth IRA described in Section 408A of the U.S. IRC.

(3) The annuity:

1. Is irrevocable and nonassignable;
2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA); and
3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)*"a"* must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant will be treated as assets transferred for less than fair market

value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

75.23(10) *Purchase of promissory notes, loans, or mortgages.*

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, will be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in subrule 75.23(1) unless the note, loan, or mortgage meets all of the following conditions:

(1) Has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA).

(2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) Prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value will be treated as assets transferred for less than fair market value regardless of whether the note, loan, or mortgage was:

(1) Purchased before February 8, 2006; or

(2) Purchased on or after February 8, 2006, and the conditions described in paragraph 75.23(9)*"a"* were met.

75.23(11) *Purchase of life estates.*

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, will be treated as assets transferred for less than fair market value unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual's home for more than its fair market value will be treated as assets transferred for less than fair market value regardless of whether the life estate was:

(1) Purchased before February 8, 2006; or

(2) Purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts (except for trusts specified in subrule 75.24(3)) established after August 10, 1993, will be treated in accordance with subrule 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will:

(1) The individual,

(2) The individual's spouse, or

(3) A person, including a court or administrative body:

1. With legal authority to act in place of or on behalf of the individual or the individual's spouse, or

2. Acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources that the individual or the individual's spouse is entitled to but does not receive because of action by:

(1) The individual,

(2) The individual's spouse, or

(3) A person, including a court or administrative body:

1. With legal authority to act in place of or on behalf of the individual or the individual's spouse, or

2. Acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule apply to the portion of the trust attributable to the individual.

d. This rule applies without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust will be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual will be considered income of the individual.

(3) Any other payments from the trust will be considered assets disposed of by the individual subject to the penalties described in rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of or income on the principal from which payment to the individual could be made will be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual will be considered income to the individual. Payments for any other purpose will be considered a transfer of assets by the individual subject to the penalties described in rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual will be considered as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified in subrule 75.23(3) and 441—Chapter 89. The value of the trust will be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule does not apply to any of the following:

a. A trust that contains the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Act) and that is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust); the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code chapter 633C, the average statewide charges and Medicaid rates are updated annually and will be published on the department's website.

c. A trust containing the assets of an individual who is disabled (as defined in Section 1614(a)(3) of the Act) that meets the following conditions:

(1) The trust is established and managed by a nonprofit association.

(2) A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools these accounts.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in Section 1614(a)(3) of the Act) by the parent, grandparent, or legal guardian of the individuals; by the individuals; or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.
[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.25(249A) Treatment of Medicaid qualifying trusts.

75.25(1) A Medicaid qualifying trust is a trust or similar legal device established on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of an intellectually disabled person who resides in an ICF-ID are exempt.

75.25(2) The amount of income and principal from a Medicaid qualifying trust that will be considered available will be the maximum amount permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available will be counted as income.

b. Trust principal (including accumulated income) considered available will be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time will be counted as income for that period of time.

c. To the extent that the trust principal and income are available only for medical care, the principal or income will not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it will be used as a third-party resource.
[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.26(249A) Conservatorships.

75.26(1) *Conservatorships established prior to February 9, 1994.* The department will determine whether assets from a conservatorship established prior to February 9, 1994, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

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

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

c. Funds in a conservatorship that are not clearly available will be considered unavailable until the conservator or court actually makes the funds available.

d. Payments received from the conservatorship for basic or special needs are considered income.

75.26(2) *Conservatorships established on or after February 9, 1994.* Conservatorships established on or after February 9, 1994, will be treated according to the provisions of paragraphs 75.24(1)*"e"* and 75.24(2)*"b."*
[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) *Class settlement payments.* Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) *Other settlement payments.* Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date

on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.28(249A) Recovery.

75.28(1) *Definitions.* For the purposes of this rule, the following definitions apply:

"Administrative overpayment" means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare Part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

"Agency error" means medical assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

"Client" means a current or former Medicaid member.

"Client error" means medical assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. "Client error" also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report as defined in rule 441—76.15(249A).

"Premiums paid for medical assistance" means monthly premiums assessed to a member or household for Medicaid or IHAWP coverage.

75.28(2) *Amount subject to recovery.* The department will recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

75.28(3) *Notification.* All clients will be promptly notified when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

a. Notification of incorrect expenditures will include:

(1) The person for whom assistance was paid;
(2) The period during which assistance was incorrectly paid;
(3) The amount of assistance subject to recovery; and
(4) The reason for the incorrect expenditure.

b. Notification of unpaid premiums will include:

(1) The amount of the premium; and
(2) The month covered by the medical assistance premium.

75.28(4) *Source of recovery.* Recovery will be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

75.28(5) *Repayment.* The repayment of incorrectly expended Medicaid funds shall be made to the department. However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an ICF-ID, or a mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department will then recover the funds from the facility through a vendor adjustment.

75.28(6) *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 2506.

75.28(7) *Estate recovery.* Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, of the member's surviving spouse, or of the member's surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.53(2)*"d."* The classification of the debt is defined in Iowa Code section 633.425(7).

a. Definitions. In addition to the definitions in subrule 75.28(1), the following definitions apply:

"Capitated payment/rate" means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

"Estate." For the purpose of this subrule, the "estate" of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes but is not limited to interest in jointly held property, retained life estates, and interests in trusts.

"Managed care organization" or *"MCO"* means an entity that:

1. Is under contract with the department to provide services to Medicaid recipients, and
2. Meets the definition of "health maintenance organization" in Iowa Code section 514B.1.

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994, when the member:

1. Is under the age of 55;
2. Is a resident of a nursing facility, an ICF-ID, or a mental health institute; and
3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member's behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department will presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due will be established. The department will notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member's behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due will be established until the department has made a decision on the member's ability to return home. If the determination is that there is or was no ability to return home, a debt due will be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member's behalf requests a determination, the department will determine if the member can or could have returned home.

(1) The department cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The department will notify the member or the member's representative and the department of the determination.

(2) If the determination is that the member can or could return home, Iowa Medicaid will establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision. The department will notify the member or the member's representative of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 2506. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. Debt collection.

(1) A nursing facility participating in the medical assistance program shall notify the department upon the death of a member residing in the facility by submitting a form prescribed by the department.

(2) Upon receipt of the form or a report of a member's death through other means, the department will request a statement of the member's assets from the member's personal representative. The representative shall sign and return a form prescribed by the department indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist.

EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened because those procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of debt.

(1) The department will waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the FPL for a household of the same size; total household resources do not exceed $10,000; and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" will be defined as being under FIP.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 249A.53(2).

(3) The department will determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 2506.

h. Amount waived. If collection of all or part of a debt is waived pursuant to paragraph 75.28(7)*"g,"* to the extent that the person received the member's estate, the amount waived will be a debt due from the following:

(1) The estate of the member's surviving spouse, upon the death of the spouse.

(2) The estate of the member's surviving child who is blind or has a disability, upon the death of the child.

(3) A surviving child who was under 21 years of age at the time of the member's death, when the child reaches the age of 21.

(4) The estate of a surviving child who was under 21 years of age at the time of the member's death, if the child dies before reaching the age of 21.

(5) The hardship waiver recipient, when the hardship no longer exists.

(6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. *Impact of asset disregard on debt due.* The estate of a member who is eligible for Medicaid under subrule 75.82(5) will not be subject to a claim for Medicaid paid on the member's behalf up to the amount of the assets disregarded by asset disregard. Medicaid paid on behalf of the member before these conditions will be recovered from the estate, regardless of the member's having purchased precertified or approved insurance.

j. *Interest on debt.* Interest will accrue on a debt due under this subrule in accordance with Iowa Code section 249A.53(2)*"e."*

k. *Reimbursement to a county.* If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code chapter 633C, the department will reimburse the county on a proportionate basis.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—75.29(249A) Investigation of eligibility. An applicant or member shall cooperate when the applicant's or member's case is selected by the department or the department of inspections, appeals, and licensing for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect Medicaid eligibility. (More information is contained in 481—Chapter 72.) Failure to cooperate will serve as a basis for denial of an application or discontinuance of Medicaid unless the Medicaid eligibility is determined by SSA. Once a person's eligibility is denied or discontinued for failure to cooperate, the person may reapply but will not be determined eligible until cooperation occurs.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.30 to **75.49** Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO FAMILY-RELATED COVERAGE GROUPS

441—75.50(249A) Eligibility factors specific to child. A child must meet the requirements of this rule to be eligible for FMAP or the coverage groups specified in subrules 75.3(6), 75.3(7), and 75.3(14).

75.50(1) *Age and school attendance.* Medicaid will be available to a child under the age of 18 without regard to school attendance.

a. The effect of age on the child's eligibility will be determined pursuant to rule 441—75.52(249A).

b. Medicaid will also be available to a child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met:

(1) A child will be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child will also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption will be continued for a reasonable period of time to complete the adjustment.

75.50(2) *Residing with a parent or other caretaker.* The child shall be living in the home of a parent or other caretaker as defined in rule 441—75.1(249A). The parent or other caretaker must meet the requirements of rule 441—75.51(249A).

a. When the mother intends to place her child for adoption shortly after birth, the child will be considered as living with the mother until the time custody is actually relinquished.

b. Living with a parent or other caretaker implies the existence of a relationship involving an accepted responsibility on the part of the caretaker for the primary care of the child. A non-parental caretaker must attest to having primary responsibility for the child's care pursuant to paragraph 75.51(2) *"b."*

c. A child can receive Medicaid in one household only. In a joint custody situation, when a child lives in the home of one parent or other caretaker some of the time and also lives in the separate home of the other parent or another caretaker, who the child will be considered to be living with is determined as follows:

(1) As specified in a court order or binding separation, divorce or custody agreement, or,

(2) If there is no such order, the parent or other caretaker with whom the child spends most nights will be considered the custodial parent or other caretaker. When a child spends equal amounts of time in the home of each parent and both parents apply for Medicaid for the child, the parents must decide which parent will continue with the application. Likewise, when a child spends equal amounts of time in the home of a parent and the home of another caretaker, the parent or other caretaker must decide which caretaker will continue with the application. If the parents, or the parent and other caretaker, cannot reach a decision, the department will make the determination based on the totality of the available information.

d. Upon the determination that a child is living with a parent or other caretaker, the Medicaid household size for each applicant or member is determined according to rule 441—75.72(249A) for the purpose of determining eligibility.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.51(249A) Eligibility factors specific to parents and caretakers.

75.51(1) *FMAP and other requirements.* To be eligible for FMAP or the coverage groups specified in subrules 75.3(6), 75.3(7), and 75.3(14), a parent or other caretaker must:

a. Meet the definition of "parent" or "caretaker" in rule 441—75.1(249A);

b. Live with an eligible child as defined in rule 441—75.50(249A); and

c. Satisfy the FMAP requirements specified in subrule 75.3(1) and the general conditions of eligibility specified in this chapter.

75.51(2) *Assumes primary responsibility for care of child.* To be eligible for FMAP, the parent or other caretaker living in the home with the child must assume primary responsibility for the care of the child.

a. A parent who is living with their child is presumed to have primary responsibility for the child's care.

b. For a child and a non-parental caretaker to meet the requirements of this subrule, the non-parental caretaker who is living with the child must attest to having primary responsibility for the child's care on an application or other document submitted to the department.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.52(249A) The effect of age on eligibility. When age is an eligibility factor and a person has reached the age limit, the birth date impacts eligibility for the birth month.

75.52(1) A person is eligible for the entire month in which the person's birth date occurs, unless the birthday falls on the first day of the month. Ineligibility based on age will be effective the first of the month following the birth month.

75.52(2) A person whose birth date is on the first day of the month is not eligible for the age-limited coverage group for the birth month. Ineligibility based on age will be effective on the person's birth date.

75.52(3) This rule applies to the following coverage groups:

a. FMAP;

b. MAC;

c. Child medical assistance program (CMAP);

d. Subsidized guardianship medically needy program;

e. Children eligible under Title IV-E;

f. State-only funded medical assistance for children in foster care or subsidized adoption;

g. State-only funded medical assistance for children in subsidized guardianship; and

h. Medicaid for former foster care youth (EMIYA).

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.53(249A) Absence from the home.

75.53(1) A person who is absent from the home will not be included in the household, except when temporarily absent as described in subrule 75.53(2).

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

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

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

75.53(2) The needs of a person who is temporarily absent from the home are included in a household if otherwise eligible. A temporary absence exists in any of the following circumstances:

a. A person is anticipated to be in a medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the person no longer being included in the household;

b. A child is out of the home to secure education or training as defined in paragraph 75.50(1)*"b"* as long as the child remains a dependent;

c. A parent or other caretaker is temporarily out of the home to secure education or training and was in the household before leaving the home to secure education or training. For this purpose, "education or training" means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment; or

d. A person is out of the home for reasons other than reasons in paragraphs 75.53(2)*"a"* through *"c"* and intends to return to the home within three months. Failure to return within three months from the date the person left the home will result in the person no longer being included in the household.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.54(249A) Pending SSI approval. When a person who would ordinarily be in the family-related Medicaid household has applied for SSI benefits, the person's needs will be included in the family-related Medicaid household pending approval of SSI.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.55(249A) Resources not considered. There is no resource test to determine eligibility for family-related Medicaid coverage groups.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.56(249A) Income eligibility. Unless otherwise stated within this chapter, income eligibility under family-related coverage groups will be determined using MAGI methodologies pursuant to Division III of this chapter.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.57 to **75.69** Reserved.

DIVISION III
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

441—75.70(249A) Financial eligibility based on MAGI. Notwithstanding any other provision of this chapter, financial eligibility for Medicaid is determined using MAGI and household income pursuant to 42 U.S.C. §1396a(e)(14) to the extent required by that section as a condition of federal funding under Title XIX of the Act. For this purpose, financial eligibility for Medicaid includes any applicable purpose for

which a determination of income is required for a coverage group that is subject to MAGI methodology as specified in rule 441—75.71(249A) and defined in rule 441—75.1(249A), including the imposition of any premiums or cost sharing.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.71(249A) Coverage groups subject to MAGI methodology. Financial eligibility will be determined under MAGI methodology for the following coverage groups:

1. FMAP as described in subrule 75.3(1).
2. MAC program as described in subrule 75.3(2).
3. Hawki as described in 441—Chapter 86.
4. IHAWP as described in 441—Chapter 74.
5. RMA as described in subrule 75.5(3).

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.72(249A) MAGI household composition. For the purpose of determining financial eligibility, each applicant's or member's household is determined based on federal tax policy and with regard to the applicant's or member's federal tax status as described below.

75.72(1) *Applicant or member is a tax-filer.* An applicant or member who expects to file a federal tax return for the year in which the applicant or member requests Medicaid and does not expect to be claimed as a tax dependent by another taxpayer is considered a tax-filer. A tax-filer's Medicaid household includes:

a. The tax-filer,

b. The tax-filer's spouse, under either of the following circumstances:

(1) The tax-filer and spouse are living together, or

(2) The expected tax status is married filing jointly, regardless of whether the spouse is present in the home, and

c. Each dependent that the tax-filer expects to claim.

75.72(2) *Applicant or member is a tax dependent.* An applicant or member who expects to be claimed as a tax dependent on a federal tax return for the year in which the applicant or member requests Medicaid is a tax dependent. A tax dependent's Medicaid household is the same as the tax-filer who claims the dependent, except the dependent's household is determined pursuant to subrule 75.72(3) when the dependent:

a. Expects to be claimed by someone other than a spouse or parent.

b. Is a child under the age of 19 who expects to be claimed by one parent while living with two parents who do not expect to file a joint return.

c. Is a child under the age of 19 who expects to be claimed by a noncustodial parent in accordance with a court order or binding separation, divorce, or custody agreement establishing physical custody controls. If there is no such order or agreement, the custodial parent is the parent with whom the child spends most nights pursuant to subparagraph 75.50(2)*"c"*(2).

75.72(3) *Applicant or member is a non-filer (does not file taxes) and is not claimed as a tax dependent.*

a. This subrule applies to an applicant or member who:

(1) Does not expect to file a federal tax return for the year in which Medicaid is requested,

(2) Does not expect to be claimed as a tax dependent for the year in which Medicaid is requested, or

(3) Meets an exception described in paragraph 75.72(2)*"a," "b,"* or *"c."*

b. The household consists of the applicant or member and each of the following who is living with and in relation to the applicant:

(1) Parent, when the applicant or member is a child under the age of 19.

(2) Spouse.

(3) Child under the age of 19.

(4) Sibling under the age of 19, when the applicant or member is a child under the age of 19.

c. For the purpose of paragraph 75.72(3)*"b,"* "living with" must be in accordance with subrule 75.50(2).

75.72(4) *Married couples.* In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of federal tax status.

75.72(5) *Pregnancy.*

a. Household size. In establishing eligibility for a pregnant woman or any person whose household includes a pregnant woman, the unborn child (or children if more than one fetus exists) will be considered when determining the number of persons in the household.

b. Verification of pregnancy. The applicant's or member's attestation of the pregnancy, date of conception, due date, and number of children expected to deliver will serve as verification unless questionable as determined by the department.

75.72(6) *Applicant or member attestation of federal tax status.* The department will accept the applicant's or member's statement of the applicant's or member's federal tax status and claimed dependents or such statement from an adult who is living with and in the Medicaid household of an applicant or member who is a child.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.73(249A) Income under MAGI methodology. The total countable earned and unearned income of the applicant or member included in the household as defined in rule 441—75.72(249A) will be considered when determining initial and ongoing Medicaid eligibility for coverage groups that are subject to MAGI methodology as specified in rule 441—75.71(249A). For eligibility to exist, the total countable monthly income of the applicant's or member's household must be at or below the income limit for the applicable coverage group pursuant to rule 441—75.74(249A).

75.73(1) *Household member income exclusions under MAGI.* The income of a household member that meets the requirements of paragraph 75.73(1)*"a"* or *"b"* is excluded from the household's total countable income.

a. Income of children under age 19.

(1) The income of a child under the age of 19 who is:

1. Included in the household of the child's parent, and

2. Not expected to be required to file a federal tax return under 26 U.S.C. Section 6012(a)(1) for the taxable year in which Medicaid is being determined, regardless of whether a tax return is filed by the child for the tax year.

(2) A child with income of less than the threshold determined annually by the IRS is considered not expected to be required to file a tax return for the taxable year in which Medicaid is being determined.

b. Income of tax dependent other than spouse or child.

(1) The income of a tax dependent other than a spouse or a child who is not expected to be required to file a federal tax return under 26 U.S.C. Section 6012(a)(1) for the taxable year in which Medicaid is being determined is not included, regardless of whether a tax return is filed by the tax dependent for the tax year.

(2) A dependent with income of less than the threshold determined annually by the IRS is considered not expected to be required to file a tax return for the taxable year in which Medicaid is being determined.

(3) Any cash support provided to the claimed dependent by the tax-filer.

75.73(2) *Countable income under MAGI.* For the purpose of determining initial and ongoing MAGI Medicaid eligibility, countable income is the amount that remains after allowable expenses and deductions have been subtracted from gross countable income as defined in paragraph 75.73(2)*"a."* Income described in paragraph 75.73(2)*"b"* is excluded as countable income. Allowable expenses and deductions are limited to those allowed in accordance with paragraphs 75.73(2)*"c"* and *"d."*

a. Gross countable income. Gross countable income under MAGI includes income types that are considered as gross income for federal tax purposes pursuant to 26 U.S.C. Sections 61 and 71 through 91 and calculated pursuant to 26 U.S.C. Section 36B(d)(2)(B), except as specified in paragraph 75.73(2)*"b."* Gross countable income for the purpose of Medicaid eligibility under MAGI includes but is not limited to the following income types:

(1) Earned income, including salaries, wages, tips and other compensation for services that include fees, commissions, fringe benefits such as sick pay, vacation pay, severance pay, and similar items, and including foreign earned income and housing expenses of a U.S. citizen or resident who lives abroad even though these types of income may not be taxable.

(2) Gross profit derived from a self-employment trade or business as defined in paragraph 75.73(2)*"e"* and 26 U.S.C. Section 1402;

(3) Capital gains derived from dealings in assets or property;

(4) Interest (taxable and non-taxable);

(5) Rental income, including room and board;

(6) Royalties;

(7) Taxable dividends;

(8) Alimony and separate maintenance payments;

(9) Taxable annuities;

(10) Income from life insurance and endowment contracts;

(11) Pensions;

(12) Income from discharge of indebtedness;

(13) Distributive share of partnership or S-corporation gross income;

(14) Income in respect of a deceased person;

(15) Income from an interest in an estate or trust;

(16) Deemed sponsor income;

(17) Social security benefits (taxable and nontaxable);

(18) Disability payments, including government, private, temporary and permanent payments;

(19) Unemployment Insurance Benefits (UIB);

(20) Gambling winnings;

(21) Survivor's benefits; and

(22) Strike pay.

b. Income types excluded from gross income. Income that meets the following criteria is not considered when determining countable gross income under MAGI despite the fact that the income may be considered for federal tax purposes. The exclusion of these income types is in accordance with 42 CFR Section 435.603(e).

(1) An amount received as a nonrecurring lump sum from a source that is considered in determining adjusted gross income for federal tax purposes pursuant to paragraph 75.73(2)*"a"* is counted only in the month received for determining Medicaid eligibility under MAGI. A nonrecurring lump sum received from a source that is not considered in determining adjusted gross income for federal tax purposes is entirely excluded.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights, and student financial assistance pursuant to 42 CFR Section 435.603(e)(3) is excluded from income.

(4) Student financial assistance provided under the Bureau of Indian Affairs education programs is excluded from income.

(5) Any other type of income that is not identified as countable in paragraph 75.73(2)*"a"* and is not otherwise included in "adjusted gross income" for federal tax purposes pursuant to 26 U.S.C. Section 62 is excluded from income.

c. Allowable expenses. Expenses that are allowed as deductions from gross income when determining a person's adjusted gross income for federal tax purposes pursuant to 26 U.S.C. Section 62 are subtracted from gross income as defined in paragraphs 75.73(2)*"a"* and *"b"* when determining countable income under MAGI. Allowable expenses include:

(1) Educator expenses.

(2) Certain business expenses of reservists, performing artists, and fee-based government officials.

(3) Health savings account contributions.

(4) Moving expenses for members of the Armed Forces.

(5) Deductible part of self-employment tax.

(6) Contributions to self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees of Small Employers (SIMPLE) and Qualified Plans.

(7) Self-employed health insurance contributions.

(8) Amount of penalty for early withdrawal of savings.

(9) Alimony payments made under a divorce or separation agreement executed before January 1, 2019.

(10) Certain individual retirement account (IRA) contributions.

(11) Student loan interest expense.

(12) Expenses directly related with the conduct of a self-employment trade or business, including but not limited to depreciation and capital losses.

d. MAGI Income Deduction. An amount equal to 5 percent of the FPL for the applicable household size will be subtracted from the total monthly countable MAGI income amount when:

(1) An applicant's monthly MAGI income exceeds the highest income limit of all of the coverage groups for which the applicant meets the categorical requirements, and

(2) Deducting 5 percent results in the applicant's income being within the income limit of the coverage group with the highest income limit for which the applicant meets categorical requirements.

e. Self-employment defined for MAGI purposes. A person is considered self-employed if the person:

(1) Carries on a trade or business with the goal of making a profit and is the sole proprietor of the trade or business, or

(2) Is an independent contractor and the person paying for the work has the right to control or to direct only the result of the work and not how the work will be done.

75.73(3) *Income verification.* The department will accept an applicant's or member's attestation of income and use the attested income to determine eligibility when the attested amount is reasonably compatible with electronic data sources as defined in rule 441—75.1(249A).

a. Verification not required. The department will not require the applicant or member to provide verification when attested income is reasonably compatible with EDS or verification is available to the department from other sources.

b. Verification required. When attested income is not reasonably compatible with EDS or verification is not available to the department from other sources, the applicant or member must provide verification of the income in accordance with 441—subrule 76.8(2) or provide a statement that reasonably explains the discrepancy between the attested income and electronic data sources.

75.73(4) *Budgeting procedures for determining financial eligibility under MAGI.* Initial and ongoing financial eligibility under MAGI is based on current monthly household composition and income with consideration given to any anticipated changes or fluctuation in income or expenses pursuant to 42 CFR Section 435.603(h). Total countable earned and unearned income of all persons in the applicant or member household after applicable expenses and deductions is considered in determining financial eligibility under MAGI in accordance with subrules 75.73(1) and 75.73(2).

a. Current monthly household income. Both initial and ongoing eligibility will be based on current monthly income when current income and any applicable expenses are a good indicator of future income except when the income is unemployment insurance benefits as described in paragraph 75.73(4)*"c."*

b. Change in current month's income. If the household indicates that current countable income is not indicative of future income due to a change that is reasonably expected to occur in the current or next month, the amount of monthly income used for initial and ongoing eligibility will be calculated based on the change. When the anticipated change is with unemployment insurance benefits, income will be budgeted as described in paragraph 75.73(4)*"c."*

c. Unemployment insurance benefits (UIB). When current income includes UIB, the monthly amount of UIB income used for initial and ongoing eligibility will be determined by annualizing the remaining balance according to the applicable item below:

(1) For applicants, the monthly amount is determined by using the remaining balance as of the first day of the month in which the application was filed and dividing the balance by 12. If the UIB will end in the application month, the annualized amount will be used for the application month only and no UIB income will be used for months thereafter.

(2) For members in the review process described in rule 441—76.14(249A), the monthly amount is determined by using the remaining balance as of the first day of the month of the new certification period

and dividing the balance by 12. If the UIB will end in the first month of the new certification period, the annualized amount will be used for the first month and no UIB income will be used for months thereafter.

(3) For members reporting a change and not due for review as described in rule 441—76.14(249A), the monthly amount is determined by using the remaining balance as of the first day of the month in which the change can be acted upon in accordance with rule 441—76.16(249A).

d. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, will be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract will be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently will be prorated over the period covered by the income and applied to the eligibility determination for the same number of months.

EXCEPTION: Periodic or intermittent income from self-employment will be treated as described in paragraph 75.73(4)*"h."*

(3) Applicable expenses and deductions will be applied to the monthly prorated income.

e. Conversion of weekly or biweekly income to a monthly amount. When income received weekly or biweekly (once every two weeks) is projected for future months, it will be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result will be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

f. Self-employment income. Countable income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis will be annualized (annual income averaged over a 12-month period of time) to arrive at the monthly amount to be used to determine eligibility, even if the income is received within a short period of time during that 12-month period. Countable self-employment income is gross countable income as defined in paragraph 75.73(2)*"a"* less allowable expenses pursuant to subrule 75.73(2)*"c."* Any change in self-employment will be handled in accordance with subparagraph 75.73(4)*"f"*(3).

(1) When a self-employment enterprise that does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income will be averaged over the period of time the enterprise has been in existence to arrive at a projected monthly amount to be used to determine eligibility. If the enterprise has been in existence for such a short time that there is very little income information or income in the period of time is not a good indicator of future income, the department will establish, with the cooperation of the applicant or member, a reasonable estimate of the projected monthly income to be used for eligibility.

(2) The policies outlined in this paragraph apply when self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established, permanent, ongoing change in the operating expenses of a self-employment enterprise that will result in a significant change in the person's annual net income. Change in self-employment income is defined as a change that will result in a significant change in the person's annual income.

1. When an applicant or member reports that change in operating expenses has occurred and the person's self-employment income has been annualized, the department will recalculate the expenses on the basis of the change.

2. When a change in self-employment income occurs and the person's self-employment income has been annualized, the department will recalculate income and expenses on the basis of the change.

3. A change in the cost of producing self-employment income or income received from self-employment that occurs as a result of seasonal business fluctuations is not considered a change for the purpose of this subparagraph.

g. Rounding procedures. The following rounding procedures apply when determining countable MAGI income.

(1) The third digit to the right of the decimal point in any calculation of income will be dropped.

(2) When the monthly countable income is converted to a percentage of the FPL and the resulting percentage is not a whole number, the FPL percentage is rounded up to the next whole percentage.

75.73(5) *Shared living arrangements.* When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member exclusively for the applicant's or member's needs are considered income, except as described at 75.73(1)*"b"*(3).

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441—75.74(249A) Income limits. The following income limits apply to the MAGI-related coverage groups specified below, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
FMAP	441—subrule 75.3(1); 42 CFR Part 435.110 and 435.118; Title XIX of the Act, Section 1931	1	$447
		2	$716
		3	$872
		4	$1,033
		5	$1,177
		6	$1,330
		7	$1,481
		8	$1,633
		9	$1,784
		10	$1,950
		over 10	$1,950 plus $178 for each additional person
Mothers and Children, for pregnant women	441—subrule 75.3(2); 42 CFR Part 435.116 and 435.118; Title XIX of the Act, Section 1902	215% of the FPL for the household	
Mothers and Children, for infants under one year of age		300% of the FPL for the household	
Mothers and Children, for children aged 1 through 18 years	441—subrule 75.3(2); 42 CFR Part 435.118; Title XIX of the Act, Section 1902	167% of the FPL for the household	

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441—75.75 to **75.79** Reserved.

DIVISION IV
ELIGIBILITY FACTORS SPECIFIC TO NON-MAGI-RELATED COVERAGE GROUPS, PERSONS IN MEDICAL INSTITUTIONS AND PERSONS RECEIVING LONG-TERM CARE SERVICES

441—75.80(249A) Categorical relatedness to supplemental security income (SSI). Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the SSI program administered by the SSA.

75.80(1) *SSI policy reference.* The statutes, regulations, and policy governing eligibility for SSI (collectively, "SSI policies") are found in Title XVI of the Act (42 U.S.C. Sections 1381 through 1383f), in

the federal regulations promulgated pursuant to Title XVI of the Act (20 CFR 416.101 to 416.2227), and in Part 5 of the program operations manual system published by the SSA. The program operations manual system is available online; at SSA offices in Ames, Burlington, Carroll, Cedar Rapids, Coralville, Council Bluffs, Creston, Davenport, Des Moines, Dubuque, Fort Dodge, Marshalltown, Mason City, Ottumwa, Sioux City, Spencer, and Waterloo; and through the department.

75.80(2) *Income considered.* For non-MAGI-related Medicaid eligibility purposes, income will be considered prospectively.

75.80(3) *Trust contributions.* Income that a person contributes to a trust as specified in paragraph 75.24(3)*"b"* will not be considered for purposes of determining eligibility for non-MAGI-related Medicaid.

75.80(4) *Conditional eligibility.* For purposes of determining eligibility for non-MAGI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources found at 20 CFR Sections 416.1240 through 416.1245, is not considered an eligibility methodology.

75.80(5) *Valuation of life estates and remainder interests.* In the absence of other evidence, the value of a life estate or remainder interest in property will be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate. If a Medicaid applicant or member disputes the value determined using the following table, the applicant or member may submit other evidence and the value of the life estate or remainder interest will be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.80(6) *Resource eligibility for non-MAGI-related Medicaid for children.* Resources of all household members will be disregarded when determining eligibility for children under any non-MAGI-related coverage group except for those groups in paragraphs 75.6(1)*"a"* and *"b"*; 75.6(2)*"a,""b,""c,""d,""e,"* and *"g"*; 75.6(4)*"a"*; and 75.6(5)*"a,""b,""c,"* and *"d."*
[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.81(249A) Disability requirements for non-MAGI-related Medicaid.

75.81(1) *Applicants receiving federal benefits.* An applicant receiving SSI on the basis of disability, social security disability benefits under Title II of the Act, or railroad retirement benefits based on the Social Security Act's definition of disability by the Railroad Retirement Board, will be deemed disabled without further determination of disability.

75.81(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the SSA, the department will determine eligibility for non-MAGI-related Medicaid based on disability as follows:

a. An SSA disability determination under either a social security disability (Title II) application or an SSI application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability that meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability that meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for non-MAGI-related Medicaid based on disability, initial determinations will be made by the department of workforce development's disability determination services division. The applicant or the applicant's authorized representative shall complete and submit forms as prescribed by the department.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department will stay a decision on disability pending the SSA decision on disability.

75.81(3) *Time frames for decisions.* Determination of eligibility based on disability will be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action or there is an administrative or other emergency beyond the department's or applicant's control.

75.81(4) *Reviews of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit forms as prescribed by the department.

75.81(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member will continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid will be canceled with timely notice in accordance with 441—Chapter 16. If there is an appeal to SSA within 65 days, the member will continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.81(6) *Disability redeterminations for members who attain age 18.* If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department will redetermine the member's disability after the member attains the age of 18 years. The member's disability will be redetermined:

a. Using the standards applicable to persons who are 18 years of age or older, and

b. Regardless of whether a review of the member's disability would otherwise be due.

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441—75.82(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rules 441—75.3(249A) through 441—75.8(249A), certain factors must be considered differently for persons who reside in a medical institution, as follows.

75.82(1) *Determining income from property.*

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income will be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest will be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income will be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income will be considered available as provided in the trust. In the absence of specific provisions in the trust, the income will be considered as stated above for nontrust property.

75.82(2) *Division of income between married people for non-MAGI coverage groups.*

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized spouse's income will be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution will be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.6(4). Persons treated together as a couple for income must be treated together for resources, and persons treated individually for income must be treated individually for resources. Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.6(4).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, will be treated as individuals effective the month after the month the partners cease living together. Their income will be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.6(4).

75.82(3) *Attribution of resources to institutionalized spouse and community spouse.* The department will determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department will determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by a form prescribed by the department and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete a form prescribed by the department and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process will include a match of the IRS data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse, except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)*"a"* live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or by the department.

(6) For natives of Alaska, shares of stock held in a regional or village corporation, during the period of 20 years in which the stock is inalienable, as provided in Sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act as amended to August 1, 2025.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act as amended to August 1, 2025, or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefits due either spouse for one or more months prior to the month of receipt. This exclusion is limited to the first six months following receipt.

(9) A life insurance policy (or policies) whose total face value is $1,500 or less per spouse.

(10) An amount, not more than $1,500 for each spouse, that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1,500 will be reduced by an amount equal to the total face value of all insurance policies that are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 as amended to August 1, 2025, which is subject to the treatment required by Section 216 of that Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than the minimum set by the federal spousal impoverishment provisions, then the greater of $24,000 or the federally established minimum will be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance under the federal spousal impoverishment provisions, the amount over the maximum will be attributed to the institutionalized spouse. (The minimum and maximum limits are indexed annually according to the consumer price index.) The federal spousal impoverishment provisions are defined in Section 1924(f)(2)(A)(i) of the Act (42 U.S.C. §1396r-5(f)(2)(A)(i)). If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred will be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department will provide each spouse a notice of the attribution results. The notice will state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect, or

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance. If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions are governed by procedures in 441—Chapter 2506. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there will be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to paragraph 75.83(2)*"d"* will be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance will be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance will be based on the maintenance needs allowance as provided by these rules at the time the appeal is filed.

(4) To receive the substituted allowance, the applicant will be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity will be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there will be no substitution for the cost of the annuity and the attribution will remain as previously determined.

(6) The applicant will not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside will be determined using the following calculation: the difference between the community spouse's gross monthly income not generated by countable resources (multiplied by 12) and the minimum monthly maintenance needs allowance (multiplied by 12) will be multiplied by the annuity factor for the age of the community spouse. This amount will be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.82(3)*"f"*(5).

75.82(4) *Consideration of resources of married people.*

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses will be considered in determining initial Medicaid eligibility. When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.82(3) will be considered in determining initial eligibility for the institutionalized spouse. The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse will be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources that are owned wholly or in part by the institutionalized spouse and that are not transferred to the community spouse will be counted in determining ongoing eligibility. The resources of the institutionalized spouse will not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship. The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means. The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse will not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse will count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution will be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for Medicaid effective with the seventh month if one partner would be ineligible for Medicaid or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income, and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, will be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid or would receive reduced benefits by considering them separately or if they choose to be considered together. In the month of entry into a medical institution, all resources of both spouses will be combined and will be subject to the resource limit for a married couple.

75.82(5) *Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to 191—Chapter 39 or 72.*

a. Eligibility. A person may be eligible for Medicaid under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for Medicaid under subrule 75.3(14), 75.3(15), 75.6(4), or 75.6(8), except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule.

b. Definition.

"Asset adjustment" means a $1 disregard of resources for each $1 that has been paid out under the person's qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member's qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member's spouse for payments made by the Medicaid program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—75.83(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.83(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income. Income is determined pursuant to the SSI program under Title XVI of the Act (42 U.S.C. §1396r-5(f)(2)(A)(i)), with the following exceptions.

a. MAGI-related clients. The income of a client and family whose eligibility is MAGI-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. Non-MAGI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by SSA, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. Non-MAGI-related clients returning home within three months. If SSA continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments will be exempt from client participation.

d. Married couples.

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income will be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage will be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility will be determined individually from each person's income.

e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. Clients receiving a VA pension. The amount of $90 of veteran's pension income will be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

(1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2); or

(2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.83(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear.

a. Ongoing personal needs allowance. All clients shall retain $55 of their monthly income for a personal needs allowance. Iowa Code section 249A.30A contains information regarding potential state-funded personal needs supplements.

(1) If the client has a trust described in Section 1917(d)(4) of the Act (including Medicaid income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount will not exceed $10 per month except with court approval.

(2) If the client has earned income, an additional $65 is added to the ongoing personal needs allowance from the earned income only.

b. Personal needs in the month of entry.

(1) Single person. A single person will be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room will be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility will each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance will be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses will be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse will be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client will be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction will be the SSI benefit for one person (or for a couple if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance will be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance will also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents will be considered in determining maintenance needs. The gross income of the spouse and dependent will include all monthly earned and unearned income and assistance from FIP, SSI, and state supplementary assistance. It will also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income will be considered as the SSI program considers income.

(3) Needs of spouse. The maintenance needs of the spouse will be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Act (42 U.S.C. §1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary will be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance will not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents will be established by subtracting each person's gross income from 150 percent of the monthly FPL for a family of two and dividing the result by three.

e. Maintenance needs of children (without spouse). When the client has children under the age of 21 at home, an ongoing allowance will be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income will be their gross income less the disregards allowed in FIP.

The children's maintenance needs will be determined by subtracting the children's countable income from the FIP payment standard for that number of children. However, if the children receive FIP, no deduction is allowed for their maintenance needs.

f. Client's medical expenses. A deduction will be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles, or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.84(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid will be considered a resource available to the individual for purposes of determining the individual's Medicaid eligibility and the amount of benefits to the extent that:

75.84(1) The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual's other resources or income be insufficient to pay for such care;

75.84(2) The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

75.84(3) The entrance fee does not confer an ownership interest in the community.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

441—75.85(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds the limit set annually according to subrule 75.85(1), the individual will not be eligible for Medicaid with respect to nursing facility services or other long-term care services, except as provided in subrule 75.85(2).

75.85(1) *Equity interest limit.* The limit on the equity interest in the individual's home for purposes of this rule will be increased from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

75.85(2) *Exception to disqualification.* Disqualification based on equity interest in the individual's home will not apply when one of the following persons is lawfully residing in the home:

a. The individual's spouse; or

b. The individual's child who is under the age of 21 or is blind or disabled as defined in Section 1614 of the Act.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

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CHAPTER 76
ENROLLMENT AND REENROLLMENT

[Ch 76, 1973 IDR, renumbered as Ch 911]
[Prior to 7/l/83, Social Services[770] Ch 76]
[Prior to 2/11/87, Human Services[498]]

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

441—76.1(249A) Definitions. The following definitions apply to this chapter in addition to the definitions in rule 441—75.1(249A).

"Act" or *"the Act"* means the federal Social Security Act, and all references herein are as amended to August 1, 2025.

"Authorized representative" means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, the review of eligibility and other ongoing communications with the department.

"Business hours" or *"HHS business hours"* means the hours between 8 a.m. and 4:30 p.m. Central Time during a weekday (Monday through Friday), excluding public holidays.

"Code of Federal Regulations" or *"CFR"* means the United States Code of Federal Regulations. All references to the CFR herein are as amended to August 1, 2025, unless another effective date is specified.

"Electronic account" means a web-based account established by the department for an applicant or member for communication between the department and the applicant member.

"Electronic case record" means an electronic file that includes all information collected and generated by the department regarding each individual's Medicaid eligibility and enrollment.

"Electronic date sources" or *"EDS"* means federal and state data sources with which the department conducts data matches for the purpose of determining eligibility. Federal data sources include the Internal Revenue Service (IRS), the Social Security Administration (SSA) and the United States Department of Homeland Security. State data sources include Iowa workforce development (IWD) wage and unemployment compensation, SSA, IRS, and the Public Assistance Reporting Information System (PARIS).

"Federally Facilitated Marketplace" or *"FFM"* means the health insurance marketplace established by the United States Secretary of Health and Human Services for states that choose not to set up their own marketplace or that do not get approval for one pursuant to 42 U.S.C. §18041.

"Federally Facilitated Marketplace referral" or *"FFM referral"* means an application submitted at healthcare.gov that requests help paying for health insurance. These applications are screened by the FFM and, if found to be potentially eligible for Iowa Medicaid or hawki, are transmitted via an electronic data file to the department for a final Medicaid/hawki determination.

"Health insurance marketplace" means a health insurance marketplace established pursuant to 42 U.S.C. §18031.

"Medicare savings program" refers to the limited Medicaid coverage groups that provide payment of Medicare premiums, coinsurance, and deductibles for low-income elderly or disabled individuals. Those groups are:

1. Qualified disabled and working people (QDWP) pursuant to 42 U.S.C. §1396a(a)(10)(E)(ii);
2. Qualified Medicare beneficiaries (QMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(i);
3. Specified low-income Medicare beneficiaries (SLMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(iii); and
4. Expanded specified low-income Medicare beneficiaries (ESLMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(iv).

"Presumptive provider" means an organization approved by the department to conduct and authorize presumptive eligibility determinations as described in subrule 76.7(1).

"Qualified entity" means an individual, under the supervision and authority of a presumptive provider, approved by the department to conduct and authorize presumptive eligibility determinations.

"Responsible person" means an individual recognized by the department pursuant to subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

"SSA" means the federal Social Security Administration.

"Supplemental Security Income" or *"SSI"* is a federally administered program established by Title XVI of the Social Security Act to provide supplemental income to individuals who have attained the age of 65 or are blind or disabled.

"United States Code" or *"U.S.C."* means the general and permanent laws of the United States. All references to U.S.C. herein are as amended to August 1, 2025, unless another effective date is specified.

"WIC" is the Special Supplemental Nutrition Program for Women, Infants, and Children established pursuant to 42 U.S.C. §1786.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.2(249A) Application for medical assistance. This rule describes the process of applying for medical assistance from the department. Applications for Medicaid must be made as provided in this rule.

76.2(1) *Application with the department or qualified entity.*

a. Who can file. An application may be filed by:

(1) The applicant;

(2) An adult in the applicant's household, as described in 42 CFR §435.603(f), or family, as described in 26 CFR §1.36B-1(d), including:

1. A spouse as defined in rule 441—75.1(249A);

2. A parent of an applicant child, as defined in rule 441—75.1(249A), including either parent of an unborn child;

3. A caretaker of an applicant child, when the caretaker meets the requirements of rules 441—75.1(249A) and 441—75.51(249A); or

4. A tax-filer who claims the applicant as a dependent;

(3) An authorized representative described in subrule 76.9(2); or

(4) A responsible person described in subrule 76.9(1).

b. How and where to file.

(1) An application may be filed online on the department's website or www.healthcare.gov; at any local HHS office; or at any HHS outstation at a disproportionate share hospital, federally qualified health center in Iowa, or other facility in Iowa where outstationing activities are provided. Applications may be submitted in person, by mail, by telephone at 1.855.889.7985, or by email or fax to a local HHS office. Addresses, email addresses, and fax numbers of local HHS offices are available on the department's website.

(2) An application may also be filed at the office of a qualified entity pursuant to subrule 76.7(2), a WIC office, a maternal health clinic, or a well-child clinic.

c. Form. Applications for Medicaid, including Medicaid applications for foster care and subsidized adoption, may be submitted on forms prescribed by the department.

d. Minimum application requirements. Initial applications must contain a legible name and address and must be signed under penalty of perjury, pursuant to 42 CFR §435.907(f). At least one person listed in paragraph 76.2(1)*"a"* must sign the application. Electronic (including telephonically recorded) signatures and handwritten signatures (transmitted via any electronic means) are acceptable. An application that does not include a legible name, address, and signature under penalty of perjury will not be considered a valid application and will be rejected without a determination of eligibility.

76.2(2) *Date of filing.*

a. An application is considered filed on the date a valid application is received in any place of filing specified in paragraph 76.2(1)*"b."*

b. Reserved.

c. The date of filing and effective date for applications received by a qualified entity for purposes of a presumptive Medicaid eligibility determination are further described in subrule 76.7(5).

d. The department will honor the application date of any application filed at the FFM that is subsequently transmitted to the department for an eligibility determination as described in rule 441—76.3(249A).

76.2(3) *Decision.* The department will notify the applicant of the eligibility decision pursuant to 441—Chapter 16.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.3(249A) Referrals from the FFM. Upon receipt of an FFM referral indicating that an application has been screened and that the applicant has been found to be potentially eligible for Medicaid or hawki, the department will treat the application as if it had been received directly by the department pursuant to rule 441—76.2(249A).

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.4(249A) Express lane eligibility. For purposes of the initial enrollment of a child in medical assistance, the department will use express lane procedures as allowed by 42 U.S.C.§1396a(e)(13) and as described in this rule.

76.4(1) For purposes of initial enrollment, the department will rely on a determination of the child's eligibility for the Supplemental Nutrition Assistance Program (SNAP) pursuant to 441—Chapter 65 as establishing that a child under the age of 19 meets all eligibility requirements established in 441—subrule 75.3(2) except for citizenship or alienage requirements unless:

a. The child's household already includes other persons receiving Medicaid based on the use of the modified adjusted gross income (MAGI) methodology, or

b. The child was previously granted express lane eligibility and the household has not had at least a two-month break in SNAP eligibility since that time.

76.4(2) To obtain express lane enrollment for a child, the child's household must request medical assistance for the child on forms prescribed by the department. The department will send forms to the household when a child eligible for express lane enrollment is approved for SNAP pursuant to 441—Chapter 65. An adult member of the child's household or a child receiving SNAP benefits as head of household must sign the form and return it to the department within 30 calendar days of issuance.

76.4(3) As a condition of express lane enrollment, the child must meet the citizenship or alienage requirements of rule 441—75.11(249A).

76.4(4) The month of application for express lane enrollment is the month of the child's SNAP effective date. Express lane eligibility begins on the first day of the month of the child's SNAP effective date.

76.4(5) After the initial express lane enrollment, all redeterminations of medical assistance eligibility will be made without reliance on any SNAP eligibility determination.

76.4(6) Retroactive enrollment is available pursuant to subrule 76.13(3) for any of the three months before the month of the child's SNAP effective date. The retroactive eligibility determination must be made without regard to SNAP eligibility.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.5(249A) Enrollment through SSI. Upon receipt of a referral from the SSA indicating that an individual has been approved for SSI, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The SSI recipient may be required to provide additional information when necessary to determine Medicaid eligibility. The SSI recipient may be required to attend an interview to clarify information.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.6(249A) Referral for Medicare savings program. Referrals received from the SSA pursuant to 42 U.S.C. §1320b-14(c)(3) when the individual has indicated that the individual wants to apply for the Medicare savings program will be treated by the department as an application for the Medicare savings program and will be processed as if the application were received directly by the department. The date of the individual's application with SSA will be the application date for benefits under the Medicare savings program. When requested to do so, the applicant must complete a Medicare Savings Programs

Additional Information Request form to provide additional information needed to determine Medicare savings program eligibility.
[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.7(249A) Presumptive eligibility. Persons may be temporarily and immediately enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity at a presumptive provider pursuant to this rule.

76.7(1) *Presumptive provider.* A presumptive provider is an organization approved by the department to conduct and authorize presumptive eligibility determinations. A provider organization that seeks to be authorized to make presumptive Medicaid eligibility determinations shall do all of the following:

a. Complete the required self-directed policy and system training.

b. Apply to the department using the Application for Initial/Recertification to Be a Presumptive Provider form.

c. Read the Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations form and agree in writing to its terms.

d. Comply with the requirements outlined in Iowa's Medicaid state plan.

e. Meet the definition of "qualified provider" pursuant to 42 U.S.C. §1396r-1.

f. Meet the definition of "qualified entity" in the following federal regulations for the category of persons covered:

(1) For children under the age of 19, as described in 42 CFR §435.118, the provider must meet the requirements of paragraphs (1) through (10) of the definition of "qualified entity" in 42 CFR §435.1101;

(2) For pregnant women, as described in 42 CFR §435.116, the provider must meet the requirements of 42 U.S.C. §1396r-1(b)(2);

(3) For parents and caretakers, as described in 42 CFR §435.110, the provider must meet the requirements in 42 CFR §435.1103(b);

(4) For persons aged 19 through 64, as described in 42 CFR § 435.119, the provider must meet the requirements in 42 CFR §435.1103(b);

(5) For former foster care children, as described in 42 CFR §435.150, the provider must meet the requirements in 42 CFR §435.1103(b);

(6) For persons needing breast or cervical cancer treatment (BCCT), as described in 42 U.S.C. §1396r-1b(b)(2); and

(7) For all of the categories of persons covered in subparagraphs 76.7(1)*"f"*(1) through *"f"*(6), a qualifying hospital must meet the requirements in 42 CFR §435.1110(b).

g. Be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Application for Initial/Recertification to Be a Presumptive Provider form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding by signing in writing.

76.7(2) *Qualified entity.*

a. An individual that seeks to be authorized to make presumptive Medicaid eligibility determinations under the supervision and authority of a presumptive provider shall do all of the following:

(1) Complete the required self-directed policy and system training.

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal (MPEP) Access Request.

(3) Read the Provider Memorandum of Understanding and agree in writing to its terms.

(4) Obtain confirmation of acceptance by the department that the individual is determined by the department to be capable of making presumptive Medicaid eligibility determinations.

b. In addition to the requirements in paragraph 76.7(2)*"a,"* a qualified entity for BCCT must also have either:

(1) Been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department; or

(2) A cooperative agreement with the department under the Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act as amended to August 1, 2025, to receive reimbursement for providing breast or

cervical cancer screening or diagnostic services to participants in the care for yourself breast and cervical cancer early detection program.

c. Only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations.

d. Qualified entities are required to be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal Recertification form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding in writing.

76.7(3) *How and where to file.* An applicant for presumptive Medicaid shall complete an application with a qualified entity in one of two ways:

a. Provide information in person to the qualified entity that enters the applicant's information into the MPEP system; or

b. Complete a paper application provided by the qualified entity that enters the applicant's information into the MPEP system.

76.7(4) *Signature.* An individual listed in paragraph 76.2(1)*"a"* must sign the completed paper application or a printed version of the completed MPEP application. A copy of the signed application must be maintained by the qualified entity.

76.7(5) *Date of filing and effective date of coverage.*

a. For purposes of determining the application date of filing for an ongoing eligibility determination, a paper application is valid only if it contains the applicant's legible name, address, and signature under penalty of perjury and must be date-stamped on the date it is received by the qualified entity. The date of filing as described in paragraph 76.2(2)*"a"* is used for purposes of determining the effective date of coverage for ongoing eligibility but does not determine the effective date of coverage for presumptive Medicaid.

b. The effective date of coverage for presumptive Medicaid is the date on which a qualified entity completes the presumptive eligibility determination within the MPEP system.

c. The applicant must provide to the qualified entity all information necessary to make a presumptive eligibility determination in the MPEP system.

76.7(6) *Notice and appeal rights.* The qualified entity shall inform the applicant of the eligibility decision as soon as possible but no later than two working days after the date the determination is made by the qualified entity. Timely and adequate notice requirements and appeal rights of the Medicaid program, including those outlined in 42 CFR Part 431, subpart E; Iowa Code chapter 17A; 441—Chapter 2506; and 441—Chapter 16, do not apply to determinations of presumptive eligibility under this rule.

76.7(7) *Full medical assistance eligibility determination.* All presumptive eligibility applications will be given the option within the MPEP system to also receive a full determination of eligibility for Medicaid or hawki.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—76.8(249A) Applicant and member responsibilities.

76.8(1) *Accurate information.* Clients, and those individuals acting on behalf of clients, are responsible for giving complete and accurate information needed to establish eligibility.

76.8(2) *Additional information or verification needed to determine eligibility.* An applicant or member will not be required to provide additional verifications if attested income meets the department's standards for reasonable compatibility and if the department can verify all other required information through an EDS. If attested income does not meet the department's standards for reasonable compatibility or if the department is not able to verify other required information through an EDS, the department will send the applicant or member a written request for the additional information or verification. The applicant or member must provide the additional information or verification by the requested due date or such application may be denied or Medicaid or hawki benefits may be discontinued.

76.8(3) *Time frames for providing information or verification.* Clients have ten calendar days from the date on the written request by the department to provide additional information or verification requested. If the tenth calendar day falls on a weekend or state holiday, the individual will have until the end of business

hours on the next business day to provide the information or verification. The information or verification is considered provided on the date it is received by the department.

76.8(4) *Extensions.* The applicant or member may request an extension for a reasonable period of time when the applicant or member is making every effort but is unable to secure the required information or verification.

76.8(5) *Interviews.* Applicants and members who are being evaluated on the basis of the MAGI methodology will not be required to attend an interview. Applicants and members who are being evaluated on a basis other than the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the application process. If applicable, the department will notify the applicant, authorized representative, or responsible person of the date, time, and method of the interview. Notification will be provided personally by telephone, email, mail, or fax.

76.8(6) *Failure to comply.* An application will be denied or assistance will be discontinued if:

a. The applicant or member does not attend a required interview, pursuant to subrule 76.8(5), or

b. The department does not receive one of the following by the due date indicated on the written request for additional information in accordance with subrules 76.8(2) through 76.8(4):

(1) The information, verification, or a statement that reasonably explains the discrepancy;

(2) An authorization for the department to obtain the information or verification; or

(3) A request for an extension of the due date.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.9(249A) Responsible persons and authorized representatives.

76.9(1) *Responsible person.* If an applicant or member is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased, a responsible person may act for the applicant or member.

a. Except as provided in paragraph 76.9(1)*"d,"* when the applicant or member is incompetent, incapacitated, or deceased, the responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and has a personal interest in the applicant's or member's welfare.

b. Except as provided in paragraph 76.9(1)*"d,"* when the applicant or member is unable to act on the applicant's or member's own behalf solely because the applicant or member is a minor, the responsible person shall be an adult in the child's household or family as described in paragraph 76.2(1)*"a."*

c. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative pursuant to subrule 76.9(2) to represent the applicant or member. However, the designation of an authorized representative does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

d. When there is no person as described in paragraphs 79.6(1)*"a"* through *"c"* to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member, any individual or organization may be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes the required form, attesting to the individual's or organization's inability to find a responsible person to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member.

e. The department may require verification of the applicant's or member's incompetence or death and of the responsible person's relationship to the applicant or member.

f. Copies of all correspondence the department would otherwise provide to the applicant or member will be provided to the recognized responsible person.

76.9(2) *Authorized representative.*

a. An individual or organization designated by a competent applicant or member, or by a responsible person recognized pursuant to subrule 76.9(1), or with other legal authority to do so may act on behalf of the applicant or member in the application process, in the review process, or for ongoing eligibility.

b. The designation of an authorized representative by an applicant, member, or responsible person must be in writing and must be signed and dated by the applicant, member, or responsible person.

The applicant, member, or responsible person may authorize the representative to complete and sign an application on the applicant's or member's behalf, complete and submit a review form, receive copies of the applicant's or member's notices and other communications from the department, and act on behalf of the applicant or member in all other matters with the department.

c. Legal documentation of authority to act on behalf of the applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a written authorization by the applicant or member.

d. Designations of authorized representatives, legal documentation of authority to act on behalf of the applicant or member, and modifications or terminations of designations or legal authority may be submitted via the department's website, mail, email, or fax or in person.

e. For purposes of this rule, the department will accept electronic, including telephonically recorded, signatures and handwritten signatures (including when transmitted by fax or other electronic means).

f. If the authorization:

(1) Indicates the time period or dates the authorization is to cover, the stated period or dates will be honored until or unless a rescission is submitted to the department as described in subparagraph 76.9(2)*"f"* (2) and may include subsequent applications, if necessary, that relate to the time period or dates indicated on the authorization.

(2) Does not indicate the time period or dates it is to cover, the authorization will be valid until the applicant, member, or responsible person modifies the authorization and notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the department that the representative no longer is acting in such capacity. Such notice must be in writing and should include the signature of the applicant, member, responsible person, or authorized representative, as appropriate.

g. Copies of all correspondence will be provided to the applicant or member and the authorized representative.

76.9(3) *Additional requirements applicable to all authorized representatives and responsible persons.*

a. An authorized representative or responsible person must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or member provided by the department.

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

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

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.10(249A) Right to withdraw the application. The applicant may withdraw the application at any time before the eligibility determination has been made. The applicant may request that the application be withdrawn entirely or request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of rule 441—75.8(249A).

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.11(249A) Choice of electronic notifications. The applicant is responsible to indicate whether notices and other communications are to be provided by the department in an electronic format through the individual's electronic account rather than by regular mail. The applicant may change the selection at any time. Notices and other communications provided through the individual's electronic account are deemed to be received upon the sending of an email to the individual notifying the individual of the notice or other communication.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.12(249A) Application not required.

76.12(1) *Adding a new person.*

a. Adding an eligible person. For members whose eligibility is based on the MAGI methodology, a new application is not required when an eligible person is added to an existing Medicaid household. Such a person is considered to be included in the application that established eligibility for the existing household. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date the person begins to live in the household or the date of report, whichever is later.

b. Adding a person previously ineligible due to a failure to cooperate. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing liability for support as described in 441—subrule 75.14(2) is to be granted Medicaid benefits, the earliest month for which that person may be eligible for coverage is the month that the person takes action(s) to meet the cooperation requirements described in 441—subrule 75.14(1) and as determined by child support services.

c. Adding a person previously ineligible due to failure to provide a social security number. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described in rule 441—75.9(249A) is to be granted Medicaid benefits, the person will be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number.

76.12(2) *Loss of hawki eligibility.* In those instances where a child loses hawki eligibility and has been determined eligible for Medicaid, with no break in coverage, an application for Medicaid is not required.

76.12(3) *Grace period.*

a. At application. If benefits are denied for failure to provide requested information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department will complete the eligibility determination as though the information were timely received. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the end of business hours on the next business day to provide the information. The grace period does not apply to late payment of premiums or noncooperation actions.

b. At reinstatement after cancellation (including cancellation at the time of reenrollment). Eligibility for Medicaid may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the information. The grace period does not apply to late payment of premiums or noncooperation actions.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.13(249A) Initial enrollment.

76.13(1) *Enrollment date.* The department will enroll applicants who have been determined to be eligible in the Medicaid program.

a. First day of the month. The effective date of enrollment is the first day of the month that the application was filed or the first day of the first month for which eligibility has been determined, whichever is later, with the following exceptions:

(1) Presumptive eligibility is effective on the date that presumptive eligibility was determined by a qualified entity for presumptive Medicaid eligibility determinations pursuant to subrule 76.7(5).

(2) Eligibility under the qualified Medicare beneficiary coverage group described in 441—paragraph 75.6(5)*"a"* begins on the first day of the month after the month of decision.

(3) For individuals who are approved for Medicaid and who are eligible for SSI, programs related to SSI, or state supplementary assistance, Medicaid benefits will be effective on the first day of the month for which the individual meets all eligibility requirements, including resource eligibility, as of the first moment of the first day of the month.

(4) The enrollment date for retroactive Medicaid eligibility is determined pursuant to subrule 76.13(3).

b. Care or services prior to enrollment. No payment will be made for medical care or services received prior to the effective date of enrollment.

76.13(2) *Certification for services.* The department will issue a medical assistance eligibility card to persons who have been determined to be eligible for the benefits provided under the Medicaid program, with the following exceptions.

a. Presumptive eligibility. A person who has been determined only presumptively eligible will be issued a Presumptive Medicaid Eligibility Notice of Action form that will include certification information.

b. Emergency Medicaid for noncitizens. An individual who is eligible only for limited emergency Medicaid for noncitizens pursuant to 441—subrule 75.11(4) will be issued a Notice of Action that will include certification information.

76.13(3) *Retroactive enrollment.* Medical assistance will be available for all or any of the three months preceding the month in which an application is filed to persons who meet the requirements described within this subrule.

a. Except as provided in paragraph 76.13(3)*"e,"* retroactive medical assistance will be available for the months a person was pregnant, an infant (under the age of 1), a child under 19 years of age, or a resident of a nursing facility licensed under Iowa Code chapter 135C during any of the three months preceding the month in which an application is filed and who also meets the following conditions:

(1) Has medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance in the month services were received if the application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance will be made available when an application has been made on behalf of a deceased person if the conditions in paragraph 76.13(3)*"a"* are met.

d. Persons enrolled in Medicaid based on receipt of SSI benefits who wish to apply for Medicaid benefits for the three months preceding the month of application shall complete a form provided by the department.

e. Exceptions to retroactive enrollment. This subrule does not apply to the following persons who are otherwise eligible for retroactive enrollment:

(1) Persons whose citizenship status has not been verified even if they are eligible during a 90-day reasonable opportunity period.

(2) Persons determined eligible only under presumptive Medicaid benefits.

(3) Persons eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Persons eligible only under the home- and community-based waiver services program.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.14(249A) Reenrollment. The department will review all conditions of eligibility for the purpose of determining continued enrollment in Medicaid pursuant to 441—Chapter 75.

76.14(1) *Reenrollment frequency.*

a. The department will conduct eligibility reviews for members whose eligibility is based on the MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided by rule 441—76.15(249A) and paragraph 76.14(1)*"b."*

b. The department will conduct eligibility reviews for the following coverage groups as circumstances indicate but no more frequently than once every 12 months:

(1) Transitional Medicaid as described in 441—subrule 75.3(6).

(2) Medicaid for former foster care youth (EMIYA) as described in 441—subrule 75.3(12).

(3) Postpartum Medicaid as described in 441—subrule 75.3(4).

c. The department will conduct eligibility reviews for members whose eligibility is based on non-MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided in rule 441—76.15(249A) and paragraph 76.14(1)*"b."*

76.14(2) *Reenrollment process.*

a. Reenrollment procedure. Reenrollment will be based on reliable information contained in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS. If the department is able to renew eligibility based on such information, the department must notify the individual of the eligibility determination and the basis of that determination. If any information in that notification form is inaccurate, the member must inform the department through any of the modes permitted for submission of an application under paragraph 76.2(1)*"b"* within 30 days.

b. Members whose eligibility for Medicaid is based on the MAGI methodology. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

c. Members whose eligibility for Medicaid is in non-MAGI related coverage groups. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

d. Failure to reenroll. Enrollment will end when information or documentation necessary to complete the determination of continued eligibility pursuant to subrules 76.8(2) through 76.8(4) is not returned before the end of the enrollment period. The department will notify the member of the disenrollment pursuant to 441—Chapter 16. Individuals whose eligibility ends must reapply unless the individual satisfies the requirements of subrule 76.12(3) or paragraph 76.14(2)*"e."*

e. Reconsideration period.

(1) For all coverage groups, except those specified in subparagraph 76.14(2)*"e"*(2), the department will reconsider the eligibility of an individual who is terminated for failure to submit the applicable review form as described in paragraph 76.14(2)*"b"* or *"c"* or for failure to provide necessary information in a timely manner and without requiring an application if the individual subsequently submits a review form within 90 days after the effective date of termination. The department will also reconsider eligibility as described in this subparagraph if the member provides an application form. If the ninetieth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the review form. The eligibility effective date will go back to the first day of the first month of ineligibility only if all other eligibility criteria are met for that month. Eligibility for subsequent months within the reconsideration period can still be determined even if the applicant remains ineligible for the initial reconsideration month(s), but eligibility will not be granted any earlier than the month in which all eligibility criteria are met.

(2) For qualified Medicare beneficiaries (QMB), the provisions in subparagraph 76.14(2)*"e"*(1) apply, except that the review form as described at lettered paragraph 76.14(2)*"b"* or *"c"* will be acted upon and treated like an application and the eligibility effective date will be determined pursuant to subparagraph 76.13(1)*"a"*(2).

f. Interview required. An individual whose eligibility is not based on the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the process.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.15(249A) Report of changes. As a continuing condition of enrollment for Medicaid, applicants and current members shall report changes in circumstances as required in this rule.

76.15(1) A change in circumstance that may affect the eligibility of applicants and members must be reported within ten days of the date the change occurred. Changes required to be reported are described in this subrule.

a. In coverage groups for which Medicaid eligibility is determined using the MAGI methodology, any change in the following must be reported:

(1) Income from all sources.

(2) Members of the household.

(3) School attendance.
(4) Mailing or living address.
(5) Receipt of a social security number.
(6) Health insurance premiums or coverage.
(7) Alien or citizenship status.
(8) Federal income tax filing status or claimed dependents for federal tax purposes.

b. In coverage groups for which Medicaid eligibility is not determined using the MAGI methodology, any change in the following must be reported.

EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

(1) Income from all sources.
(2) Resources.
(3) Members of the household.
(4) Recovery from disability.
(5) Mailing or living address.
(6) Health insurance premiums or coverage.
(7) Medicare premiums or coverage.
(8) Receipt of social security number.
(9) Gross income of the community spouse or of the dependent children, parents, or siblings of the institutionalized or community spouse who are living with a community spouse when a diversion is made to the community spouse or family, as those terms are defined in rule 441—75.1(249A).
(10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation, or spenddown.
(11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

d. Individuals receiving Medicaid based on the receipt of Title IV-E-funded foster care, based on an adoption assistance agreement, or based on a guardianship assistance agreement are required to report changes in health insurance coverage, when their living or mailing address changes, upon receipt of a social security number, and upon termination of the adoption assistance agreement.

e. Individuals receiving state-only funded Medicaid are required to report any change in the following:

(1) Income from all sources.
(2) Mailing or living address.
(3) Receipt of a social security number.
(4) Health insurance coverage.
(5) Alien or citizenship status.

76.15(2) Failure to report. When a change is not reported as required by this rule, any Medicaid expenditures for care or services provided when the member was not eligible will be considered overpayments and subject to recovery from the member.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.16(249A) Action on information received. When a change in circumstance is reported, or when a change in a member's circumstances otherwise comes to the attention of the department, its effect on eligibility will be evaluated and eligibility will be redetermined regardless of whether the report of change was required by rule 441—76.15(249A). When the department has information about an anticipated change in a member's circumstances that may affect eligibility, eligibility will be redetermined at the appropriate time based on such change.

76.16(1) After assistance has been approved, except as provided in subrules 76.16(2) and 76.16(3) or as otherwise stated in 441—Chapter 75 or this chapter, action based on a change reported during a month will be effective the first day of the next calendar month unless timely notice of adverse action is required as specified in rule 441—16.2(17A).

76.16(2) When a request is made to add a new person to the Medicaid household and that person meets the eligibility requirements, assistance will be acted upon pursuant to rule 441—76.12(249A).

76.16(3) When the reported change causes a change in coverage from a Medicare Savings Program coverage group described in 441—subrule 75.6(5) to coverage under Medicaid for employed people with disabilities (MEPD) as described in 441—subrule 75.6(6), the reported change will be effective the first day of the calendar month that the change was reported.

76.16(4) When the change creates ineligibility, eligibility under the current coverage group will be canceled and an automatic redetermination of eligibility will be completed in accordance with rule 441—76.17(249A).

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]

441—76.17(249A) Timeliness requirements for conducting automatic redeterminations of eligibility. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, the department will automatically redetermine eligibility for other Medicaid coverage groups unless the reason for ineligibility is due to not meeting the requirements in rule 441—76.8(249A). If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility that applies to all coverage groups, no further redetermination will be required. When the redetermination is completed, the member will be notified of the decision in writing. The redetermination process will be completed as follows:

76.17(1) *Information received by the tenth of the month.* If information that creates ineligibility under the current coverage group is received by the department by the tenth of the month, the redetermination process will be completed by the end of that month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group will be the first day of the month following the month in which the information is received, pursuant to rule 441—76.16(249A).

76.17(2) *Information received after the tenth of the month.* If information that creates ineligibility under the current coverage group is received by the department after the tenth of the month, the redetermination process will be completed by the end of the following month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group will be no earlier than the first day of the first month following the month in which the information is received, pursuant to rule 441—76.16(249A), but no later than the second month following the month in which the information is received.

76.17(3) *Change in federal law.* If a change in federal law affects the eligibility of large numbers of Medicaid members and the United States Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR §435.1003, the redetermination process will be completed within the extended time limit and the effective date of cancellation for the current coverage group will be no later than the first day of the month following the month in which the extended time limit expires.

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CHAPTER 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]]

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

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.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) *Licensure.* Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) *Survey participation.* As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs will be held confidential.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.3(249A) Pharmacists. An authorized pharmacist licensed to practice in the state of Iowa is eligible to participate in the program.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.4(249A) Hospitals.

77.4(1) *Qualifications.* All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.4(2) *Psychiatric bed tracking system.* As a condition of participation in the medical assistance program, hospitals must establish procedures for participating in and updating the statewide psychiatric bed tracking system.

a. Definitions.

"Adult beds" means the number of staffed and available psychiatric beds ready for admission to individuals 18 years of age to 60 years of age.

"Child beds" means the number of staffed and available psychiatric beds ready for admission to individuals up to the age of 18.

"Geriatric beds" means the number of staffed and available psychiatric beds ready for admission to individuals 60 years of age and older.

"Hospital," for purposes of this subrule, means any licensed hospital providing inpatient psychiatric services and the state mental health institutes.

"Psychiatric bed tracking system" means a web-based electronic system managed by the department that can be searched to locate inpatient psychiatric services at an Iowa hospital.

b. Hospitals are required to participate in the psychiatric bed tracking system.

c. Hospitals shall update the psychiatric bed tracking system, at a minimum, two times per day. The first update shall be entered between 12:00:01 a.m. and 9:59:59 a.m. each day; the second update shall be entered between 8:00:00 p.m. and 11:59:59 p.m. each day.

d. Each update must include the number of child beds by sex, the number of adult beds by sex, and the number of geriatric beds by sex.

e. Failure to comply with the psychiatric bed tracking reporting may result in sanctions in accordance with rule 441—79.2(249A).

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.5(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, however, that payment will not be made to a dental laboratory.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.6(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.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.7(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.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.8(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.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.9(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate provided that they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) as amended to July 1, 2026, 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 as amended to July 1, 2026.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.10(249A) Home health agencies. Home health agencies are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) and, unless otherwise exempted, have submitted a surety bond as required by subrules 77.10(2) through 77.10(4).

77.10(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.

77.10(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the department 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 through 9308 and 31 CFR Part 223, both as amended to July 1, 2026, and 31 CFR Parts 224 and 225, both as amended to July 1, 2026. 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 will 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 will be maintained and will be available for public inspection by contacting 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.

77.10(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.

77.10(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with 42 CFR 484 Subparts A, B, and C as amended to July 1, 2026, and with the Medicare Program Integrity Manual, Chapter 10.2.5.3, as amended to July 1, 2026.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.11(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.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.12(249A) Ambulance service. Providers of ambulance service are eligible to participate provided that they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) and Iowa Code section 147A.8.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.13(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission (TJC) accreditation, or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. The Department, pursuant to 441—Chapter 24.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.14(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.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.15(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.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.16(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they are accredited pursuant to 441—Chapter 24.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.17(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 rule 441—78.18(249A) and meet the department'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 department.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.18(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.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.19(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.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.20(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026).
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.21(249A) Independent laboratories. Independent laboratories are eligible to participate provided that they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.22(249A) Rural health clinics. Rural health clinics are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026).
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.23(249A) Psychologists.

77.23(1) All psychologists licensed to practice in the state of Iowa pursuant to Iowa Code chapter 154B 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 credentialing requirements of the National Register of Health Service Psychologists as amended to July 1, 2026.

77.23(2) A psychologist provisionally licensed to practice in the state of Iowa pursuant to Iowa Code section 154B.6 is eligible to participate in the medical assistance program when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist.

77.23(3) A psychologist provisionally licensed in another state is eligible to participate when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist who is duly licensed to practice in that state.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.24(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) for more information). The prenatal and postpartum care shall be in accordance with the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services, as amended to July 1, 2026.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.25(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if the ambulatory surgical centers are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the dental board has issued a current permit pursuant to 481—Chapter 579 for any dentist to administer deep sedation or general anesthesia at the facility.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.26(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 the federally qualified health centers' eligibility as allowed by Section 6404(b) of Public Law 101–239 as amended to July 1, 2026.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.27(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 481—Chapter 621.

77.27(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 481—Chapter 621.

77.27(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.27(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.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.28(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.28(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.28(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.29(249A) Physician associates. All physician associates licensed to practice in the state of Iowa are eligible for participation in the program. Physician associates duly licensed to practice in other states are also eligible for participation.
[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.30(249A) HCBS habilitation services. To be eligible to participate in the Medicaid program as an approved provider of HCBS habilitation services, a provider shall meet the general requirements in subrules 77.30(2) through 77.30(5) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.30(1) *Definitions.*

"Certified employment specialist" or *"CES"* means a person who has earned a CES certification through a nationally recognized accrediting body.

"Guardian" means a guardian appointed in probate or juvenile court.

"Home- and community-based services" or *"HCBS"* means the types of person-centered care delivered in the home and community.

"Immediate family member" means any of the following:

1. Husband or wife.
2. Natural or adoptive parent, child, or sibling.
3. Stepparent, stepchild, stepbrother, or stepsister.
4. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
5. Grandparent or grandchild.
6. Spouse of grandparent or grandchild.

"Individual employment" means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job and for which the member is paid at or above minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

"Individual placement and support" or *"IPS"* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org as amended to July 1, 2026.

"Intensive residential service homes" or *"intensive residential services"* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions.

"IPS 25-item supported employment fidelity scale" means the fidelity scale published by the IPS Employment Center as amended to July 1, 2026, resulting in scores of exemplary fidelity, good fidelity, fair fidelity, or not supported employment.

"IPS implementation" means the process advocated by the IPS Employment Center as amended to July 1, 2026.

"IPS reviewer" means a person who is qualified to complete fidelity reviews of IPS services and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa that has obtained a fidelity score of "good" or better; has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS reviewer; and has shadowed one or more IPS fidelity reviews;
2. An existing IPS reviewer from a state that is a member of the IPS International Learning Collaborative;
3. An IPS reviewer contracted directly from the IPS Employment Center;
4. A CES with a bachelor's degree who has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS reviewer and has shadowed one or more IPS fidelity reviews.

"IPS team" means, at a minimum, an IPS employment specialist, a behavioral health specialist, Iowa Vocational Rehabilitation Services (IVRS) counselor, and a case manager or care coordinator.

"IPS trainer" means a person who is qualified to provide training and technical assistance for IPS implementation and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa that has obtained a fidelity score of "good" or better and has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS trainer;
2. An existing IPS trainer from a state that is a member of the IPS International Learning Collaborative;
3. An IPS trainer contracted directly from the IPS Employment Center;
4. A CES with a bachelor's degree who has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS trainer.

"Managed care organization" or *"MCO"* means the same as defined in 441—Chapter 73.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Mental health diagnosis" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association as amended to July 1, 2026, excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention as defined in the current version of the DSM published by the American Psychiatric Association as amended to July 1, 2026.

"Prospective IPS team" means a group that is forming an IPS team to deliver IPS services but who has not yet completed implementation phase 4a as amended to July 1, 2026.

"Provider-owned or controlled setting" means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord/tenant laws do not apply, the state will ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

"Provisionally approved IPS team" means a group that has (1) formed a team to deliver IPS services, (2) completed implementation phase 4a as amended to July 1, 2026, and (3) begun to deliver IPS services.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder in a child under 18 that significantly impairs the child's ability to function in family, school, or community settings. This impairment must be substantial and have lasted long enough to meet specific diagnostic criteria outlined in the DSM as amended to July 1, 2026.

"Severe and persistent mental illness" or *"SPMI"* means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles.

77.30(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.

77.30(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 set forth in the HCBS habilitation provider manual as amended to July 1, 2026.

77.30(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.

77.30(5) *Residential and nonresidential settings.* All HCBS, whether residential or nonresidential, shall be provided in accordance with 42 CFR 441.301(4) and (5) as amended to July 1, 2026.

77.30(6) *Case management.* A provider is eligible to participate in the HCBS habilitation program as a provider of case management services if accredited as a case management provider pursuant to 441—Chapter 24.

77.30(7) *Day habilitation.*

a. The following providers may provide day habilitation:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide services that qualify as day habilitation under 441—subrule 78.27(8).

(2) An agency that is accredited by CARF to provide other services and has begun 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 subparagraph 77.25(7)*"a"*(1),*"a"*(4), or *"a"*(7).

(3) An agency that is not accredited by CARF but has applied to CARF 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 CARF is no longer a qualified provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) 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.

(6) An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

(7) An agency that is accredited by the International Center for Clubhouse Development.

(8) An agency that is accredited by TJC.

b. Direct support staff providing day habilitation services shall meet the qualifications as outlined in the HCBS Manual as amended to July 1, 2026.

77.30(8) *Home-based habilitation.*

a. The following agencies may provide home-based habilitation services:

(1) An agency that is certified by the department to provide home-based habilitation services.

(2) An agency that is accredited under 441—Chapter 24 to provide supported community living services.

(3) An agency that is accredited by CARF as a community housing or supported living service provider.

(4) An agency that is accredited by the Council on Quality and Leadership (CQL).

(5) An agency that is accredited by the Council on Accreditation of Services for Families and Children.

(6) An agency that is accredited by TJC.

b. Agencies meeting the criteria under subrule 77.30(9) or 77.40(2) that seek certification as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter. A certified intensive residential service provider shall:

(1) Be enrolled as an HCBS 1915(i) home-based habilitation provider in good standing with Iowa Medicaid.

(2) Provide staffing 24 hours per day, 7 days per week, 365 days per year.

(3) Maintain a minimum staffing ratio of one staff to every two residents. Staffing ratios shall be responsive to the needs of the individuals served.

(4) Ensure that all staff members have the qualifications outlined in the HCBS Manual as amended to July 1, 2026.

(5) Ensure that within the first year of employment, staff members complete 48 hours of training in the subject matter outlined in the HCBS Manual as amended to July 1, 2026.

(6) Provide coordination with the individual's clinical mental health and physical health treatment and other services and supports.

(7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual and any other plans developed for the individual.

(8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services.

(9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.

(10) Accept and serve eligible individuals who are court-ordered to intensive residential services.

(11) Provide services to eligible individuals on a no-reject, no-eject basis.

(12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site with approval from the department.

(13) Be located in a neighborhood setting to maximize community integration and natural supports.

(14) Demonstrate specialization in serving individuals with a serious and persistent mental illness or multi-occurring conditions and serve individuals with similar conditions in the same site.

c. Direct support staff providing home-based habilitation services shall meet the qualifications outlined in the HCBS Habilitation Manual as amended to July 1, 2026.

d. The department will approve living units designed to serve up to four persons, except as necessary to prevent an overconcentration of living units in a geographic area.

e. The department will approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of living units in a geographic area; and

(2) The county in which the living unit is located provides to the department verification in writing that approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need; or
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.30(9) *Prevocational habilitation.*

a. The following providers may provide prevocational services:

(1) An agency that is accredited by CARF as an organizational employment service provider or a community employment service provider.

(2) An agency that is accredited by the Council on Quality and Leadership.

(3) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall, within six months of hire, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE)-certified training program as amended to July 1, 2026.

(3) Prevocational direct support staff shall complete four hours of continuing education in employment services annually.

77.30(10) *Supported employment habilitation.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by CARF as an organizational employment service provider or a community employment service provider.

(2) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as supported employment under 441—subrule 78.27(10). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(3) An agency that is accredited by CARF to provide other services and began providing services that qualify as supported employment under 441—subrule 78.27(10) since the agency's last accreditation survey. The agency may provide supported employment services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.30(10)*"a"*(1), *"a"*(2), *"a"*(5), *"a"*(6), *"a"*(7) or *"a"*(8).

(4) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as supported employment under 441—subrule 78.27(10). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(5) An agency that is accredited by the COA.

(6) An agency that is accredited by TJC.

(7) An agency that is accredited by the Council on Quality and Leadership.

(8) 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 on Quality and Leadership in Supports for People with Disabilities is no longer a qualified provider.

(9) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations.

c. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the qualifications outlined in the HCBS Habilitation Manual and HCBS Waiver Manual, both as amended to July 1, 2026.

d. Providers qualified to offer IPS services shall meet the following requirements:

(1) Providers shall meet the provider qualifications listed in this subrule.

(2) Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years.

(3) Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall

be made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder.

(4) Providers shall receive training and technical assistance throughout IPS implementation from an IPS trainer. Evidence of the IPS team's agreement for such training and technical assistance shall be made available to the department at the time of enrollment.

(5) Prospective IPS teams shall complete IPS implementation as defined in subrule 77.30(1).

(6) Prospective IPS teams are provisionally approved until the IPS team has obtained at least a "fair" score on a baseline fidelity review completed by IPS reviewers.

(7) Provisionally approved IPS teams shall complete IPS implementation phases 1 through 4a as amended to July 1, 2026, within 12 months of enrolling.

(8) Upon completion of IPS implementation phase 4a as amended to July 1, 2026, provisionally approved IPS teams shall deliver IPS services according to the IPS outcomes model.

(9) Upon completion of IPS implementation phase 7 as amended to July 1, 2026, IPS teams are qualified to deliver IPS services, subject to the following:

1. IPS teams must obtain a baseline fidelity review score of "fair" or better within 14 months of completion of IPS implementation phase 1. The fidelity review must be completed by IPS reviewers. The fidelity reviews shall be provided to the department upon receipt by the IPS team.

2. In the event an IPS team fails to achieve a fidelity score of "fair" or better, the IPS team shall receive technical assistance to address areas recommended for improvement as identified in the fidelity review. If the subsequent fidelity review results in a score of less than "fair" fidelity, the IPS team will be provisionally approved for no more than 12 months or until the fidelity score again reaches "fair" fidelity, whichever date is earlier.

3. IPS teams that do not achieve a "fair" fidelity score within 12 months from being provisionally approved will no longer be qualified to deliver IPS services until they again reach the minimum "fair" fidelity score.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.31(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.31(1) *Licensed marital and family therapists (LMFT).* Any person licensed by the board of behavioral health professionals as a marital and family therapist pursuant to 481—Chapter 880 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.31(2) *Temporarily licensed marital and family therapists.* Any person who holds a temporary license to practice marital and family therapy pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed marital and family therapist provides treatment under the supervision of a qualified marital and family therapist as determined by the board of behavioral health professionals by rule. Claims for payment for such services must be submitted by the supervising licensed marital and family therapist.

77.31(3) *Licensed independent-level social workers (LISW).* Any person licensed by the board of social work as an independent-level social worker pursuant to 481—Chapter 880 is eligible to participate. An independent-level social worker in another state is eligible to participate when duly licensed to practice in that state.

77.31(4) *Licensed master-level social workers (LMSW).*

a. A person licensed by the board of social work as a master-level social worker pursuant to 481—Chapter 880 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-level social worker licensed pursuant to 481—Chapter 880.

b. A master-level 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-level social worker duly licensed in that state.

77.31(5) *Licensed mental health providers (LMP).* Any person licensed by the board of behavioral health professionals as a mental health provider pursuant to Iowa Code chapter 154D and 481—Chapter 880 is eligible to participate. A mental health provider in another state is eligible to participate when duly licensed to practice in that state.

77.31(6) *Temporarily licensed mental health counselors.* Any person temporarily licensed by the board of behavioral health professionals as a mental health counselor pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed mental health counselor provides treatment under the supervision of a qualified mental health counselor as determined by the board of behavioral health professionals by rule. Claims for payment for such services must be submitted by the supervising licensed mental health counselor.

77.31(7) *Certified alcohol and drug counselors.* Any person certified by the nongovernmental Iowa board of certification as an alcohol and drug counselor is eligible to participate.

77.31(8) *Licensed behavior analysts.* Any person licensed as a behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate. A licensed behavior analyst in another state is eligible to participate when duly licensed to practice in that state.

77.31(9) *Licensed assistant behavior analysts.* A person licensed by the board of psychology as an assistant behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate when the licensed assistant behavior analyst:

a. Holds current certification as an assistant behavior analyst by a certifying entity; and

b. Provides treatment under the supervision of a behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

77.31(10) *Registered behavior technicians.*

a. A person is eligible to participate as a registered behavior technician when the person holds:

(1) A current certification from the behavior analyst certification board as a registered behavior technician; or

(2) A bachelor's degree.

b. A registered behavior technician must provide treatment under the supervision of a behavior analyst or assistant behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.32(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.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.33(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.

77.33(1) Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

77.33(2) Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

77.33(3) Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

77.33(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

b. Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

c. Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

d. Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

e. Registered by the nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

77.33(5) Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620.

77.33(6) Personnel providing vision services shall be:

a. Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

b. Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

c. Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.34(249A) Case management provider organizations. Case management provider organizations meeting the criteria in 441—Chapter 24 are eligible to participate.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.35(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by an agency meeting the standards and qualifications pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.35(18) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards set forth below for the service to be provided and the HCBS provider manual as amended to July 1, 2026.

77.35(1) *Home maintenance providers.* Home maintenance providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

77.35(2) *Home health aide providers.* Home health aide providers shall be agencies that are certified to participate in the Medicare program.

77.35(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections, appeals, and licensing (DIAL) as being in compliance with the standards for adult day services programs in 481—Chapter 70.

77.35(4) *Nursing care providers.* Nursing care providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.35(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) Hospitals licensed pursuant to 481—Chapter 51.

(3) Nursing facilities, intermediate care facilities for individuals with intellectual disabilities, 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 through 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home maintenance providers that meet the conditions of participation set forth in subrule 77.35(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.35(3).

(8) Residential care facilities for individuals with intellectual disabilities licensed by DIAL.

(9) Assisted living programs certified by DIAL.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The member’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 member's physician and the parents, guardian, or primary caregiver.

4. The member's medical issues, including allergies.

5. The member's daily schedule that includes the member'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 members and the public. Nonprescription medications shall be labeled with the member'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 member'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.

77.35(6) *Counseling providers.* Counseling providers shall be:

a. Agencies that are certified under the community mental health center standards set forth in 441—Chapter 24.

b. Agencies that are licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24.

77.35(7) *Attendant care providers.* The following providers may provide attendant care service:

a. Agencies authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

b. Home health agencies that are certified to participate in the Medicare program.

c. Community action agencies as designated in Iowa Code section 216A.93.

d. Providers certified under an HCBS waiver for supported community living.

e. Assisted living programs that are certified by DIAL under 481—Chapter 69.

f. Adult day service providers that are certified by DIAL under 481—Chapter 70.

g. Community businesses that are engaged in the provision of attendant care services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.35(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.40(2) or 77.42(12).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

77.35(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 441—Chapter 226.

b. Community action agencies as designated in Iowa Code section 216A.93.

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 coverage.

77.35(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the following conditions:

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 per 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 that 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 applicable laws and regulations 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.

77.35(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 441—Chapter 226. 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 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.35(2).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Homemaker service providers meeting the standards set forth in subrule 77.35(1).

77.35(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 481—Chapter 921:

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. Independent dietitians licensed pursuant to 481—Chapter 921.

77.35(13) *Financial management service.* Members who select the consumer choices option may 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 obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

c. The financial institution shall enroll as a Medicaid provider.

77.35(14) *Independent support brokerage.* Members who select 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 member'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 member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.35(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(17) *Self-directed community supports and employment.* Members 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 outlined in the HCBS Manual as amended to July 1, 2026.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.36(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.

77.36(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.36(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.37(249A) Hospice providers. Hospice providers that are licensed and meet the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under the Medicare program for hospice programs are eligible to participate in the Medicaid program.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.38(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who meets the training and qualification specified in the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers are eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.38(22) and the integrated,

community-based settings standards in subrule 77.30(5) and also meet the standards set forth below for the service to be provided.

77.38(1) *Adult day care providers.* Adult day care providers meeting the criteria outlined in subrule 77.35(3) are eligible to participate.

77.38(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 per 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 that 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 applicable laws and regulations 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.

77.38(3) *Home health aide providers.* Home health aide providers meeting the criteria outlined in subrule 77.35(2) are eligible to participate.

77.38(4) *Homemaker service providers.* Homemaker service providers meeting the criteria in subrule 77.35(1) are eligible to participate.

77.38(5) *Nursing care.* Nursing care providers meeting the criteria in subrule 77.35(4) are eligible to participate.

77.38(6) *Respite care.* Respite care providers meeting the criteria in subrule 77.35(5) are eligible to participate.

77.38(7) *Home-delivered meals providers.* Home-delivered meals providers meeting the criteria outlined in subrule 77.35(11) are eligible to participate.

77.38(8) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.38(9) *Mental health outreach providers.* Community mental health centers or other accredited behavioral health providers meeting the criteria outlined in rule 441—77.31(249A) may provide mental health outreach services.

77.38(10) *Transportation service providers.* The following providers may provide transportation services:

a. Area agencies on aging as designated in 441—Chapter 226. 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 department of transportation.

d. Supported community living providers certified pursuant to subrule 77.40(2) or 77.42(12).

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation broker.

77.38(11) *Nutritional counseling.* Providers meeting the criteria outlined in subrule 77.35(12) may provide nutritional counseling.

77.38(12) *Assistive device providers.* The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to 441—Chapter 226.

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.38(13) *Companion services.* Senior companion programs designated by the Corporation for National and Community Service may provide companion services.

77.38(14) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.38(15) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications in subrule 77.35(13).

77.38(16) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the criteria outlined in subrule 77.35(14).

77.38(17) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.38(18) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.38(19) *Self-directed community supports and employment.* Members 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 outlined in subrule 77.35(17).

77.38(20) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the standards outlined in 441—Chapter 90.

77.38(21) *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 set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, except for 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.

77.38(22) *Assisted living on-call service.* Assisted living on-call service providers shall be assisted living programs that are certified by DIAL under 481—Chapter 69.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.39(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who meets the training and qualification specified in the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program.

77.39(1) *Counseling providers.* Counseling providers that meet the criteria outlined in subrule 77.35(6).

77.39(2) *Home health aide providers.* Home health aide providers that meet the requirements outlined in subrule 77.35(2).

77.39(3) *Home maintenance providers.* Home maintenance providers that meet the requirements outlined in subrule 77.35(1).

77.39(4) *Nursing care providers.* Nursing care providers that meet the requirements outlined in subrule 77.35(4).

77.39(5) *Respite care providers.* Respite care providers that meet the criteria outlined in subrule 77.35(5).

77.39(6) *Home-delivered meal providers.* Home-delivered meal providers that meet the criteria outlined in subrule 77.35(11).

77.39(7) *Adult day care providers.* Adult day care providers that meet the criteria outlined in subrule 77.35(3).

77.39(8) *Attendant care providers.* Attendant care providers that meet the criteria outlined in subrule 77.35(7).

77.39(9) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.39(10) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.39(11) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.39(12) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.39(13) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

77.39(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers, except for providers of goods and services purchased under the consumer choices option or home-delivered meals, 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 set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.40(249A) HCBS intellectual disability waiver service providers. HCBS intellectual disability waiver services shall be rendered by providers meeting the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.40(1) *Review of providers.* Reviews of compliance with standards as indicated in this chapter and the requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, will be conducted by designated department team members.

77.40(2) *Supported community living (SCL) providers.*

a. The department will contract only with public or private agencies to provide the SCL service. The department does not recognize individuals as service providers under the SCL program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable rules in 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of SCL 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 rules in 441—Chapters 112 and 113.

d. Agencies meeting the criteria under subrule 77.40(2) that seek designation as an intensive residential service provider shall meet the criteria pursuant to paragraph 77.30(8)*"b"* at initial application and annually thereafter.

e. All SCL providers shall meet the following requirements:

(1) The provider shall demonstrate the outcomes and processes in this rule for each of the members being served.

(2) Reserved.

77.40(3) *Respite care providers.* Respite care providers meeting the criteria in subrule 77.35(5) are eligible to participate.

77.40(4) *Supported employment providers.* Supported employment providers meeting the criteria outlined in subrule 77.25(9) are eligible to participate.

77.40(5) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.40(6) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.40(7) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.40(8) *Home health aide providers.* Home health aide providers meeting the criteria outlined in subrule 77.35(2) are eligible to participate.

77.40(9) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.40(10) *Interim medical monitoring and treatment providers.* Interim medical monitoring and treatment providers meeting the criteria outlined in subrule 77.35(8) are eligible to participate.

77.40(11) *Residential-based supported community living service providers.*

a. The department will only enroll 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 children with an intellectual disability or brain injury under 441—Chapter 116.

(3) Agencies certified by the department to provide residential-based supported community living services. Residential-based supported community living service providers shall 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 intellectual disabilities and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every three 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 member 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 member. The service provider shall distribute the policies for member 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 the interRAI assessment tool as amended to July 1, 2026.

(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 the interRAI assessment tool as amended to July 1, 2026.
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 supported 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 department may provide living units of up to eight beds. The department shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) 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.

(2) The provider supplies the department 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 77.42(7).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.42(8).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department will 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, annual recertification will be based on an on-site review and will be contingent upon demonstration of compliance with certification requirements.

The department will hold an exit conference with the provider to share preliminary findings of the recertification review. The department will write and send to the provider a review report within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification will be effective on the date identified on the certificate of approval and will 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 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 department review team member encounters a situation that places a member in immediate jeopardy, the department review team member will immediately notify the provider and other department review team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member 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 will not be certified. The department will immediately discontinue funding for that provider's service. If this action is appealed and the member 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 members deemed to be at risk.

5. Abuse reporting. As a mandatory reporter, each department review team member will follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department will 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 that 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 subrule 70.40(1) and numbered paragraph 77.40(11)*"f"*(3)"4."
- The provider has failed to provide information requested pursuant to subrule 70.40(1) and numbered paragraph 77.40(11)*"f"*(3)"4."
- The provider refuses to allow the department to conduct a site visit pursuant to subrule 77.40(1) and subparagraph 77.40(11)*"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 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 2506.

(4) Providers of residential-based supported community living services will be subject to reviews of compliance with program requirements.

77.40(12) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.40(13) *Adult day care providers.* Adult day care providers meeting the criteria outlined in subrule 77.35(3) are eligible to participate.

77.40(14) *Prevocational service providers.* Prevocational service providers meeting the criteria outlined in subrule 77.30(9) are eligible to participate.

77.40(15) *Day habilitation providers.* Day habilitation services may be provided by agencies meeting the qualifications outlined in subrule 77.30(7).

77.40(16) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.40(17) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.40(18) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.40(19) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.40(20) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.41(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.41(1) *Minimum composition.* At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.41(2) *Psychiatrists.* A psychiatrist on the team shall be a physician (MD or DO) who:

a. Is licensed under 481—Chapter 653;

b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; and

c. Has experience treating serious and persistent mental illness.

77.41(3) *Registered nurses.* A nurse on the team shall:

a. Be licensed as a registered nurse under 481—Chapter 617, and

b. Have experience treating persons with serious and persistent mental illness.

77.41(4) *Behavioral health service providers.* A mental health service provider on the team shall be:

a. A mental health counselor or marital and family therapist who:

(1) Is licensed under 481—Chapter 880, and

(2) Has experience treating persons with serious and persistent mental illness; or

b. A social worker who:

(1) Is licensed as a master-level or independent-level social worker under 481—Chapter 880, and

(2) Has experience treating persons with serious and persistent mental illness.

77.41(5) *Psychologists.* A psychologist on the team shall:

a. Be licensed under 481—Chapter 880, and

b. Have experience treating persons with serious and persistent mental illness.

77.41(6) *Substance abuse treatment professionals.* A substance abuse treatment professional on the team shall:

a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)*"b,"* and

b. Have at least three years of experience treating substance abuse.

77.41(7) *Peer specialists.* A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.41(8) *Community support specialists.* A community support specialist on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and

b. Has experience supporting persons with serious and persistent mental illness.

77.41(9) *Case managers.* A case manager on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),

b. Has experience managing care for persons with serious and persistent mental illness, and

c. Meets the qualifications of "qualified case managers and supervisors" in rule 441—24.1(225A).

77.41(10) *Advanced registered nurse practitioners.* An advanced registered nurse practitioner on the team shall:

a. Be licensed under 481—Chapter 621,

b. Have a mental health certification, and

c. Have experience treating serious and persistent mental illness.

77.41(11) *Physician associates.* A physician associate on the team shall:

a. Be licensed under 481—Chapter 780,

b. Have experience treating persons with serious and persistent mental illness, and

c. Practice under the supervision of a psychiatrist.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.42(249A) HCBS brain injury (BI) waiver service providers. HCBS BI waiver service providers shall meet the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026. Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct member service must have completed the department's brain injury training modules within 60 days from the beginning date of service provision, with the exception of staff members

who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), 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 member served or the parent or stepparent of a member 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 77.42(10). 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 subrule 77.42(1) and be evaluated according to subrules 77.42(7) through 77.42(9) and meet the requirements of subrules 77.42(2) through 77.42(6). Respite providers shall also meet the standards outlined in subrule 77.42(1).

The integrated, community-based settings standards in subrule 77.30(5) apply to all HCBS BI waiver service providers.

77.42(1) *Outcome-based standards.* The provider shall have organizational and rights and dignity outcome-based standards pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.42(2) *The right to appeal.* Members 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 that affects the member. The provider shall distribute the policies for member appeals and procedures to members.

77.42(3) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers a prescription or an over-the-counter medication, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with rule 481—63.16(135C).

77.42(4) *Research.* If the provider conducts research involving members, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that members' rights are protected.

77.42(5) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS BI waiver service providers, except for providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation, 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 set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.42(6) *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.

77.42(7) *Certification process.* The department will conduct reviews of compliance with standards for initial certification and recertification. Certification carries no assurance that the approved provider will receive funding.

The department may request any information from the prospective service provider that the department considers pertinent to arriving at a certification decision.

77.42(8) *Initial certification.* The department will 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 will 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.

b. The department's decision on the provider's initial certification will 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.

c. Providers applying for initial certification will be offered technical assistance.

77.42(9) *Period of certification.* Provider certification will become effective on the date identified on the certificate of approval and will terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification will be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department will be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification will be based on an on-site review unless the provider has been accredited for similar services by TJC, CARF, the Council on Quality and Leadership (the Council), or COA. The on-site reviews for supported community living and supported employment use interviews with members and significant people in the member's life to determine whether or not the individual value-based outcomes set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, and corresponding processes are present for the member. Respite services are required to meet certain outcome standards and participate in satisfaction surveys.

(1) Once the outcomes and processes have been determined for all the members in the sample, a department review team then determines which of the 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 members interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the members interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the member, length of certification will be based more heavily on whether or not the processes are in place to help members obtain desired outcomes.

(2) An exit conference will be held with the organization to share preliminary findings of the certification review. The department will write and send a review report to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

(3) Provider certification will become effective on the date identified on the Certificate of Approval and will terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification will 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 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.

(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 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) 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 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.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period will 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 will not be renewed or extended and will require a full on-site follow-up review to be completed. The provider will 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 department team member encounters a situation that places a member in immediate jeopardy, the department team member will immediately notify the provider and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) 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 will not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, 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 members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each department team member will 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 that 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 will 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 77.42(10)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.42(10)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.42(10)*"f."*

(4) There are instances of noncompliance with the standards that were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department 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 2506.

77.42(10) *Departmental reviews.* The department will conduct reviews of compliance with standards as indicated in this chapter. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, members, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews will be conducted annually with additional reviews conducted at the department's discretion.

b. Following a departmental review, the department will 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 provider shall submit the corrective action plan to the department 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 77.42(10)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.42(11) *Case management service providers.* Case management service provider organizations are eligible to participate in the Medicaid HCBS BI waiver program provided the case management service provider organizations meet the standards in 441—Chapter 24 and the case management service provider organizations are the department, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.42(12) *Supported community living providers.*

a. The department will 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 rules in 441—Chapters 108, 112, and 114 through 116.

c. Providers of services 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. Providers of services may employ or contract individuals meeting the definition of host home to provide supported community living services. These individuals must meet the criteria in the HCBS Waiver Manual as amended to July 1, 2026. A host home is a community-based family home setting whose owner or renter provides HCBS SCL or HCBS home-based habilitation (HBH) services to no more than two unrelated individuals who reside with the owner or renter in their primary residence and whose owner or renter is approved to provide those services as an independent contractor of a community-based SCL or HBH service agency.

e. The department will approve living units designed to serve up to four persons, except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department will approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the department in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.42(13) *Respite care providers.* Respite care providers meeting the criteria outlined in subrule 77.35(5) are eligible to participate.

77.42(14) *Supported employment providers.* Supported employment providers meeting the criteria outlined in subrule 77.30(10) are eligible to participate.

77.42(15) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.42(16) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.42(17) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.42(18) *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 that provide specialized medical equipment as described in 441—subrule 78.43(8).

77.42(19) *Adult day care providers.* Adult day care providers shall be agencies that meet the criteria outlined in subrule 77.35(3).

77.42(20) *Family training providers.* Family training providers shall be one of the following:

a. Providers certified under the community mental health center standards set forth in 441—Chapter 24 and that employ staff to provide family 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 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 set forth in 441—Chapter 24 and that employ staff to provide family 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 HCBS BI waiver service providers pursuant to rule 441—77.42(249A) that employ staff to provide family training who meet the definition of a "qualified brain injury professional" as set forth in rule 441—83.81(249A).

f. Agencies that are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

77.42(21) *Prevocational habilitation.* Prevocational habilitation services providers meeting the criteria outlined in subrule 77.30(9) are eligible to participate.

77.42(22) *Positive behavioral support and consultation providers.* Positive behavioral support and consultation providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, the positive behavioral support and consultation providers must meet the following requirements:

a. Behavior assessment and development of an appropriate intervention plan with periodic reassessment of the appropriate intervention plan and training of staff who shall implement the appropriate intervention plan must be done by a "qualified brain injury professional" as defined in rule 441—83.81(249A). Formal assessment of the members' 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 that are certified under the community mental health center standards set forth in 441—Chapter 24.

(2) Agencies that are licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under Medicare for hospice programs.

(3) Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24.

(4) Home health aide providers meeting the standards outlined in subrule 77.35(2). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) HCBS BI waiver service providers certified pursuant to rule 441—77.42(249A).

(6) Agencies that are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

(7) Individuals who meet the definition of "qualified brain injury professional" as defined in rule 441—83.81(249A).

77.42(23) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.42(24) *Interim medical monitoring and treatment providers.* Interim medical monitoring and treatment providers meeting the criteria outlined in subrule 77.35(8) are eligible to participate.

77.42(25) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.42(26) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.42(27) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.42(28) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.42(29) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.43(249A) HCBS physical disability waiver service providers. HCBS physical disability waiver service providers shall meet the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026. The integrated, community-based settings standards in subrule 77.30(5) apply to all HCBS physical disability waiver service providers.

77.43(1) *Enrollment process.* The department will conduct reviews of compliance with standards for initial enrollment. Enrollment carries no assurance that the approved provider will receive funding and 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.

77.43(2) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.43(3) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.43(4) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.43(5) *Specialized medical equipment providers.* Specialized medical equipment providers meeting the criteria outlined in subrule 77.42(18) are eligible to participate.

77.43(6) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.43(7) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications in subrule 77.35(13).

77.43(8) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.35(14).

77.43(9) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.35(15).

77.43(10) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.35(16).

77.43(11) *Self-directed community supports and employment.* Members who select 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 subrule 77.35(17).

77.43(12) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers, except for 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, 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 set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.44(249A) Public health agencies. A public health agency is eligible to participate in the medical assistance program when the public health agency serves as a public health entity within a local board of health jurisdiction pursuant to rule 641—77.3(137).

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.45(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, 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) as amended to July 1, 2026; and
2. Meets the following additional requirements.

77.45(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 board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

b. Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

c. Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Licensed by the board of educational examiners as a mental health professional pursuant to rule 282—16.9(256);

(2) Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

(3) Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

(4) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(5) Registered by the nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

e. Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapter 617 through 620.

f. Personnel providing vision services shall be:

(1) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

(2) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(3) Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

g. Developmental services shall be provided by personnel who meet standards established pursuant to rule 281—120.31(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 rule 281—41.403(256B);

(2) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(3) Endorsed by the board of educational examiners as a speech-language pathologist pursuant to 282—subrule 27.3(3);

(4) Endorsed by the board of educational examiners as an orientation and mobility specialist pursuant to rule 282—22.12(256);

(5) Endorsed by the board of educational examiners as a school occupational therapist pursuant to rule 282—16.5(256);

(6) Endorsed by the board of educational examiners as a school physical therapist pursuant to rule 282—16.6(256);

(7) Endorsed by the board of educational examiners as a school nurse pursuant to rule 282—16.4(256);

(8) Endorsed by the board of educational examiners as a school social worker pursuant to rule 282—16.7(256);

(9) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620; or

(10) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654.

77.45(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—41.24(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the IFSP.

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441—77.46(249A) Local education agency (LEA) services providers. School districts accredited by the department of education pursuant to 281—Chapter 12 and Iowa educational services for the blind and the Iowa school for the deaf, both of which are governed by the department of education pursuant to Iowa Code section 256.95, are eligible to participate in the medical assistance program as providers of LEA services under rule 441—78.50(249A) if the following conditions are met.

77.46(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 board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

b. Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

c. Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(2) Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

(3) Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

(4) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(5) Registered by the board of nursing as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

e. Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620.

f. Personnel providing vision services shall be:

(1) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

(2) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(3) Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

g. Developmental services shall be provided by personnel who meet standards established pursuant to rule 281—120.13(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 rule 281—41.403(256B);

(2) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(3) Endorsed by the board of educational examiners as a speech-language pathologist pursuant to 282—subrule 27.3(3);

(4) Endorsed by the board of educational examiners as an orientation and mobility specialist pursuant to rule 282—22.12(256);

(5) Endorsed by the board of educational examiners as a school occupational therapist pursuant to rule 282—16.5(256);

(6) Endorsed by the board of educational examiners as a school physical therapist pursuant to rule 282—16.6(256);

(7) Endorsed by the board of educational examiners as a school nurse pursuant to rule 282—16.4(256);

(8) Endorsed by the board of educational examiners as a school social worker pursuant to rule 282—16.7(256);

(9) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620; or

(10) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654.

77.46(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.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.47(249A) Indian health facilities. A health care facility operated by the U.S. Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638 as amended to July 1, 2026) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 U.S.C. 1603 as amended to July 1, 2026, is eligible to participate in the medical assistance program if the following conditions are met.

77.47(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.47(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.48(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 77.48(1) and the integrated, community-based settings standards in subrule 77.30(5) and also meet

the standards in subrules 77.48(2) through 77.48(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.

77.48(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 member or the parent or stepparent of the member.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the outcome-based standards for the rights and dignity of children with serious emotional disturbance as set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

(2) The department will 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 will include interviews with the member and the member'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 will 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 will 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, except for providers of environmental modifications and adaptive devices, 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 incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.48(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 intellectual disability or BI 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.

77.48(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) Behavioral health intervention providers qualified under rule 441—77.13(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. Staff training. As a condition of providing family and community support services under the children's mental health waiver, the agency shall meet the staff training requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

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 rule 441—24.1(225A) that is developed by each member's interdisciplinary team as set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

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.

77.48(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 481—Chapter 880 or possessing an equivalent license in another state.

b. Staff training. As a condition of providing in-home family therapy under the children's mental health waiver, the agency shall meet the training requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

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 rule 441—24.1(225A) that is developed by each member's interdisciplinary team.

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.

77.48(5) *Respite care providers.* Respite care providers meeting the criteria outlined in subrule 77.35(5) are eligible to participate.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.49(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.50(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.51(249A) Community-based neurobehavioral rehabilitation services.

77.51(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" means services provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's needs.

77.51(2) *Eligible providers.* The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

77.51(3) *Provider standards.* All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members' needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

(4) The program administrator shall be a CBIST through the ACBIS or a CBIS under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department. The administrator shall be present in the assigned location for 25 hours per week. In the event of an absence from the assigned location exceeding four weeks, the organization shall designate a qualified replacement to act as administrator for the duration of the assigned administrator's absence.

(5) A minimum of 75 percent of the organization's administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor's degree in a human services-related field;

2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;

3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or

4. Be a CBIS certified through the ACBIS or have other nationally recognized brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members.

b. The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum, the training includes the following:

(1) Completion of the department-approved brain injury training modules.

(2) Member rights.

(3) Confidentiality and privacy.

(4) Dependent adult and child abuse prevention and mandatory reporter training.

(5) Individualized rehabilitation treatment plans.

(6) Major mental health disorder basics.

c. Within 30 days of commencement of direct service provision, employees shall complete nationally recognized cardiopulmonary resuscitation (CPR) certification, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually, with the exception of CPR certification, which must be renewed prior to expiration of the certification.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by subparagraph 77.51(3)*"a"*(6).

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training. A majority of eligible employees within 12 months of the commencement of direct service provision shall be CBIS certified through ACBIS or have other nationally recognized brain injury certification as approved by the department.

f. The organization shall have in place an outcome management system that measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

g. The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

(1) Measure and analyze organizational activities and services quarterly.

(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.

(3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.30(3) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

h. The organization shall have in place written policies and procedures and a personnel 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 organization's governing body shall have an active role in the administration of the organization.

j. The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

k. The organization shall implement outcome-based standards for rights and dignity.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.52(249A) Qualified Medicare beneficiary (QMB) providers. Any Medicare provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a QMB provider. A QMB-eligible member must meet the criteria outlined in 441—paragraph 75.6(5)*"a"*.

77.52(1) *Reimbursement.* A QMB provider may only bill the department for the QMB-eligible member's Medicare cost-sharing obligations. Reimbursement is limited to coinsurance, copayments, and deductibles for Medicare-covered services.

77.52(2) *Definitions.*

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Medicare cost sharing" means the Medicare member's responsibility for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

"Qualified Medicare beneficiary" or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)*"a."* Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums, coinsurance, copayment, and deductible (except for Part D).

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.53(249A) Health insurance premium payment (HIPP) providers. Any provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a HIPP provider. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket, cost-sharing obligations. Reimbursement is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance paid for through the HIPP program. HIPP-eligible members must meet the criteria outlined in rule 441—75.21(249A).

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.54(249A) Crisis response services.

77.54(1) *Definitions.* The terms used in this rule shall have the same meaning as those set out in 441—Chapter 24.

77.54(2) *Eligible providers.* Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24 are eligible to participate in the program by providing crisis response services, crisis stabilization community-based services, and crisis stabilization residential services.

77.54(3) *Provider standards.* All providers of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services shall meet the standards criteria as set forth in 441—Chapter 24.

[**ARC 0314D**, IAB 5/27/26, effective 7/1/26]

441—77.55(249A) Subacute mental health services.

77.55(1) *Definitions.* The terms used in this rule shall have the same meaning as set out in Iowa Code section 135G.1.

77.55(2) *Subacute mental health services.* Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

77.55(3) *Eligible provider.* Subacute mental health care facilities that are licensed by DIAL in accordance with 481—Chapter 71 are eligible to participate in the program by providing subacute mental health services.

77.55(4) *Provider standards.* All providers of subacute mental health services shall meet the standards criteria as set forth in 481—Chapter 71.

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These rules are intended to implement Iowa Code section 249A.4.

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◊ Two or more ARCs

1 December 15, 2002, effective date of 77.37(14)*"e"*(2) and 77.39(13)*"e"* delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL SERVICES
[Prior to 7/1/83, Social Services[770] Ch 78]
[Prior to 2/11/87, Human Services[498]]

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

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician, including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment will be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician associate (PA), or advanced registered nurse practitioner (ARNP)) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the department.

b. Treatment of certain foot conditions as specified in paragraphs 78.15(3)*"a"* and *"b."*

c. Acupuncture treatments.

d. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program will be utilized in determining when a given procedure is unproven or experimental in nature.

e. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by Iowa Medicaid or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admission to the hospital. Approval will be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" will be published by the department in the provider manuals for hospitals and physicians as amended to July 1, 2026. The "Outpatient/Same Day Surgery List" will be developed by Iowa Medicaid and will include procedures that can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. Iowa Medicaid may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

f. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.
(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.
(3) Disposable irrigation trays or sets.
(4) Disposable catheterization trays or sets.
(5) Indwelling Foley catheter.
(6) Disposable saline enemas.
(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308 and 155A.27. For the purposes of the medical assistance program, prescriptions for medical supplies are required and will be subject to the same provisions.

d. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug are not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury.

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the VFC program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for any "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery that can be expected primarily to improve physical appearance or that is performed primarily for psychological purposes or that restores form but that does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders. This subparagraph is intended to implement Iowa Code section 249A.14.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures that are not covered under the program. This list is for example purposes only and is not considered all-inclusive.

(1) Any procedure performed for personal reasons to improve the appearance of an obvious feature or part of the body that would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures that are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Facelifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties unless there is evidence of accidental injury occurring within the past six months that resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage will not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 441—78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment will be made for the services of a private duty nurse.

78.1(8) Payment for mileage will be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit, the allowance will be based on a follow-up home visit. When more than one patient is seen in a single visit, payment will be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

(1) It is necessary for the physician to travel outside the home community, and

(2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care that are performed by a nurse practitioner or PA as specified in 42 CFR 483.30(f) as amended to July 1, 2026. On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Reserved.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision.

(1) Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

(2) Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

(3) ARNPs certified under board of nursing rules in 481—Chapter 621 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. ARNPs who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

(4) A PA licensed under board of PAs' professional licensure rules in 481—Chapters 780 through 784 is exempt from the direct personal supervision requirement, except as expressly required by Iowa Code chapter 148C or 481—Chapters 780 through 784. A physician shall be accessible at all times for consultation with a PA unless the PA is providing emergency medical services pursuant to 481—subrule 781.1(3). PAs who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A) or required by rules in 481—Chapters 780 through 784. PAs who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the Special Supplemental Nutrition Program

for Women, Infants, and Children (WIC), a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care will be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and that is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) A department consent form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the department form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent, except in the case of premature delivery or emergency abdominal surgery that occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs 78.1(16)*"b"* through *"f"* shall be effectively presented to a blind, deaf, hard-of-hearing, or otherwise disabled individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16)*"b"* shall be attached to the claim for payment and shall be signed by all parties required by the form.

i. Informed consent shall not be obtained while the individual to be sterilized is:

(1) In labor or childbirth,

(2) Seeking to obtain or obtaining an abortion, or

(3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment of having been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing,

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy, and the physician has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when a Certification Regarding Abortion form is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman's life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. The Certification Regarding Abortion form shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. The Certification Regarding Abortion form shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids shall be the same as described in rule 441—78.6(249A).

78.1(19) Preprocedure review by Iowa Medicaid will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures that have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by Iowa Medicaid will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by Iowa Medicaid. If not so approved by Iowa Medicaid, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from Iowa Medicaid.

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of

leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by Iowa Medicaid. Covered liver transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by Iowa Medicaid. Covered heart transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by Iowa Medicaid. Covered transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph 78.1(2)*"a"*(5).

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

3. The pancreas transplants listed under this subparagraph require preprocedure review by Iowa Medicaid.

4. Covered transplants are payable only when performed in a facility that meets the requirements of subrule 78.3(10).

5. Transplantation of islet cells or partial pancreatic tissue is not covered.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph 78.1(20)*"a."*

78.1(21) Utilization review. Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term "physician" does not include a psychiatrist.

78.1(22) Risk assessment. Risk assessment, using the Medicaid Prenatal Risk Assessment form, will be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral will be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement will be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) Reserved.

78.1(24) Topical fluoride varnish. Payment will be made for application of an FDA-approved topical fluoride varnish, as defined by the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association as amended to July 1, 2026, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment will be available only for application of topical fluoride varnish, which will be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening will not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician's supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

78.1(25) Prior authorization for medication-assisted treatment will be governed pursuant to subrule 78.28(2).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for "covered outpatient drugs" as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) as amended to July 1, 2026, subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(39).

78.2(2) *Prescription required.* As a condition of payment for all drugs, including "nonprescription" or "over-the-counter" drugs that may otherwise be dispensed without a prescription or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy. All prescriptions or drug orders shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990 as amended to July 1, 2026).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed department Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

(4) Prior authorization for medication-assisted treatment will be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act as amended to July 1, 2026.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Reserved.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 as amended to July 1, 2026, and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations as amended to July 1, 2026 (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes.

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration (FDA).

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the FDA but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4) as amended to July 1, 2026.

78.2(5) *Nonprescription drugs.*

a. Nonprescription or over-the-counter (OTC) refers to a drug that may be lawfully sold without a prescription; however, Iowa Medicaid requires a prescription for covered OTC drugs. These drugs are subject to prior authorization requirements as specified in the preferred drug list (PDL) published by the department pursuant to Iowa Code section 249A.20A. The drugs are identified on the nonprescription (OTC) prescribed list by therapeutic category located on the PDL website (www.iowamedicaidpdl.com) under the PDL/PA tab.

b. Nonprescription drugs for use in a nursing facility, psychiatric medical institution for children (PMIC), or intermediate care facility for persons with an intellectual disability (ICF/ID) will be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID, with the exception of OTC insulin and pseudoephedrine.

78.2(6) *Quantity prescribed.*

a. Quantity prescribed. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

b. Prescription refills.

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and
- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990) as amended to July 1, 2026, a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation can be found in rules of the Iowa board of pharmacy.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by Iowa Medicaid. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. The criteria are available from Iowa Medicaid or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity require prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided to inpatients subject to the same provisions specified in subrule 78.2(1) and subparagraphs 78.2(4)*"b"*(1) through *"b"*(10), except for *"b"*(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided to outpatients subject to the same provisions specified in subrules 78.2(1) through 78.2(4), except for subparagraph 78.2(4)*"b"*(7). The basis of payment for drugs provided to outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the VFC program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital will be made to those hospitals certified by the department of inspections, appeals, and licensing as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment will be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Payment will be made for medically necessary inpatient acute psychiatric intensive care services that meet the criteria in this subrule, pursuant to 441—paragraph 79.1(5)*"i."* This inpatient rate is only applicable to individuals 18 to 64 years of age. All inpatient acute psychiatric intensive care services require prior authorization.

a. "Acute psychiatric intensive care" is defined as care provided for a condition with rapid onset that is accompanied by severe symptoms and is generally of brief duration, requiring emergency treatment and critical care.

b. To meet the need for acute psychiatric intensive care, the patient must:

(1) Have a serious and persistent mental illness as defined in 441—subrule 77.25(1);

(2) Have a current, severe, imminent risk of serious harm to self or others; and

(3) Display additional complexity of need related to:

1. Complex comorbidities, including intellectual or developmental disability, autism spectrum disorder, substance use disorders, or traumatic brain injuries; or

2. A history of violence or current aggression that is secondary to mental illness; or

3. A request for patient transfer that has been rejected by inpatient level of care by one or more hospitals due to severity of symptoms; or

4. Lack of responsiveness to typical interventions or a condition that is treatment refractory; or

5. Disorganized psychotic state or manic thought process that impairs the ability to function or risks the safety of the patient or others; or

6. Behavior that causes disruption to the general milieu of the unit (i.e., instigating other patients in negative ways); or

7. High elopement risk; or

8. Any other atypical reason that the treating mental health provider feels that additional resources are needed to keep the patient and others around the patient safe.

c. The individual must have a documented need for acute intensive care requiring increased or specialized staffing, equipment, or facilities, based on two or more of the following:

(1) Fall precaution protocol in place;

(2) Restraints or seclusion room requirements;

(3) Requiring assistance with activities of daily living;

(4) Requirements for complex nursing care;

(5) Acutely impaired cognitive functioning from baseline;

(6) Documentation of interventions to address acute complex mental illness and comorbidities;

(7) Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure;

(8) Elopement risk precaution protocol in place.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-

designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified. The team should consist of:

1. A surgeon director.
2. A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

1. Anesthesiology.
2. Cardiology.
3. Dialysis.
4. Gastroenterology.
5. Hepatology.
6. Immunology.
7. Infectious diseases.
8. Nephrology.
9. Neurology.
10. Pathology.
11. Pediatrics.
12. Psychiatry.
13. Pulmonary medicine.
14. Radiology.

15. Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include persons with expertise in the following areas available at the transplant center:

1. Anesthesiology.
2. Blood bank services.
3. Cardiology.
4. Cardiovascular surgery.
5. Dialysis.
6. Dietary services.
7. Gastroenterology.
8. Infection control.
9. Laboratory services (pathology, microbiology, immunology, tissue typing, and immunosuppressive drug monitoring).
10. Legal counsel familiar with transplantation laws and regulations.
11. Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.
12. Respiratory therapy.
13. Pharmaceutical services.
14. Physical therapy.
15. Psychiatry.
16. Psychosocial.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI) as amended to July 1, 2026. As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year. For approval of an extrarenal organ transplant program it is highly desirable that the institution:

1. Has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or
2. Has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success

and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level. To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network. Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria. The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

1. Risk and benefit.
2. Morbidity and mortality.
3. Long-term survival.
4. Quality of life.
5. Recipient demographic information.

These data should be compiled and maintained at the transplant center monthly. The transplant center will submit the above data to the United Network for Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research. Ongoing research regarding the transplanted organs is required. The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program. The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient. The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program. The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process. The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to Iowa Medicaid. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½-by-11-inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to Iowa Medicaid.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

(1) There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

(2) Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes that would affect its approved status. Specifically, a facility must report any significant decrease in its experience level

or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16)*"a"* and *"r"* to determine if a medical emergency exists. Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual's health unless immediate medical treatment is given. The determination of whether a medical emergency exists will be based on the patient's medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by Iowa Medicaid to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)*"f"* plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)*"f,"* with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective:

a. As of the date of notice by Iowa Medicaid that the lower level of care is required, or

b. For the days Iowa Medicaid determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by Iowa Medicaid to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—paragraph 81.5(16)*"f"* plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—paragraph 81.5(16)*"f,"* with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective:

a. As of the date of notice by Iowa Medicaid that the lower level of care is required, or

b. For the days Iowa Medicaid determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by Iowa Medicaid. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the Iowa Medicaid medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by Iowa Medicaid pursuant to 441—Chapter 2506.

78.3(16) Skilled nursing care in "swing beds."

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections, appeals, and licensing and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)*"f"* and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 81.5(16)*"f"* with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.

(2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16)*"a."*

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member's LOC needs, using a department Swing Bed Certification form.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member's LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member's needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an "appropriate" nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

78.3(17) Reserved.

78.3(18) Preprocedure review by Iowa Medicaid is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from Iowa Medicaid.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.4(249A) Dental services. Payment is authorized only for medically necessary dental and oral surgery services provided by a dentist to the extent these services are permitted to be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures.

78.4(1) *Preventive services.* Payment will be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride, once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion, or there is too little dental ridge to accommodate

either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

78.4(2) *Diagnostic services.* Payment will be made for the following diagnostic services:

a. A comprehensive oral evaluation once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panographic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bite-wing films only once in a 12-month period.

e. Single periapical films when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts only for orthodontic cases or dental implants or when requested by Iowa Medicaid.

l. Cone beam images when medically necessary for situations including but not limited to detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) *Restorative services.* Payment will be made for the following restorative services:

a. Treatment of dental caries in those areas that require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials only once for the same restoration in a two-year period.

c. Crowns when there is at least a fair prognosis for maintaining the tooth as determined by Iowa Medicaid and when a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval will be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or when there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval will be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

d. Cast post and core, post and composite or post and amalgam in addition to a crown when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

e. The following restoration procedures, as indicated:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth will be paid as a one-surface restoration (i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid).

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(5) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(6) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(7) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(8) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) *Periodontal services.* Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing once every 24 months when prior approval has been received. Prior approval will be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater.

c. Periodontal surgical procedures including gingivoplasty, osseous surgery, and osseous allograft when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft with prior approval. Authorization will be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene.

e. Periodontal maintenance therapy, which requires prior authorization. Approval will be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater.

f. Tissue regeneration procedures, which require prior authorization. Approval will be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents, which requires prior authorization. Approval will be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) *Endodontic services.* Payment will be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment, including gross underfilling, perforations, and canal blockages with restorative materials.

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment will be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) *Oral surgery—medically necessary.* Payment will be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

78.4(7) *Prosthetic services.* Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval will be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval will be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture.

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval will be granted for members who:

(1) Have a physical or mental condition that precludes the use of a removable partial denture, or

(2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval will be granted for members who meet the criteria for a removable partial denture and:

(1) Have a physical or mental condition that precludes the use of a removable partial denture, or

(2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period.

j. Adjustments to a complete or removable partial denture when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization will be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period, which requires prior authorization. Approval will be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval will also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase, which requires prior approval. Approval will be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea, which requires prior approval and must be custom-fabricated. Approval will be granted in accordance with Medicare criteria.

78.4(8) *Orthodontic procedures.* Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval will be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval will be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and will be granted when the member has a severe handicapping malocclusion as defined by the department and when determined to be medically necessary.

78.4(9) *Adjunctive general services.* Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. Payment will not be made for writing prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment that warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval will be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

78.4(11) *Emergency services.* Payment will be made for emergency services as defined in and pursuant to the requirements set forth in 42 CFR 438.114 as amended to July 1, 2026.

78.4(12) *Prior authorization.* Certain dental services require prior authorization as set forth in this rule. Covered dental service categories requiring prior approval are further defined and outlined in the Iowa Medicaid Dental Services Provider Manual as amended to July 1, 2026.

78.4(13) *Service setting.* When dental services cannot be safely performed in a dental office, they may be provided in a hospital or ambulatory surgical center and reimbursed in accordance with rule 441—78.26(249A).

78.4(14) *Compliance.* Payment requires compliance with Iowa Medicaid policies, clinical criteria, and documentation requirements as specified in the Iowa Medicaid Dental Services Provider Manual as amended to July 1, 2026.

78.4(15) *Annual benefit maximum.*

a. Members 21 years of age or older have an annual benefit maximum of $1,000 per state fiscal year for coverage of dental services set forth in this rule. Payment for services exceeding the $1,000 annual benefit maximum is the responsibility of the member.

b. The following services do not count toward the annual benefit maximum:

(1) Preventive services;

(2) Diagnostic services;

(3) Fabrication of removable dentures and related services;

(4) Anesthesia when provided in conjunction with oral surgery codes approved for payment; or

(5) Emergency services.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term "flatfoot" is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)*"c."* Payment will be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Provider Manual as amended to July 1, 2026, from Iowa Medicaid. Payment will not be made for writing prescriptions.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) *Payable professional services.* Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage will be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage will be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Reserved.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through seven years of age.
3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Reserved.

h. Repairs or replacement of frames, lenses or component parts. Payment will be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment will be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment will be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

(1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.

(2) Up to eight gas permeable contact lenses are allowed every 12 months for children one through three years of age.

(3) Up to six gas permeable contact lenses are allowed every 12 months for children four through seven years of age.

(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.

(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) *Ophthalmic materials.* Ophthalmic materials that are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated.

b. Standard plastic, plastic and metal combination, or metal frames.

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance as amended to July 1, 2026.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

(1) Spectacle lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Safety frames.

(5) Subnormal visual aids.

(6) Photochromatic lenses.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval will be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process will be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include but are not limited to hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment will be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint will be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms will be granted for members whose vision cannot be adequately corrected with other covered prisms.

78.6(5) *Noncovered services.* Noncovered services include but are not limited to the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for occupational eye safety.

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Sunglasses.

f. Progressive bifocal or trifocal lenses.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies are the same as described in rule 441—78.6(249A).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

b. The neuromusculoskeletal conditions listed on the department's website indicate whether the conditions require short-, moderate-, or long-term CMT. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment will be made for subsequent X-rays, absent a new condition, consistent with paragraph 78.8(3)*"c."* No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors will be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays will be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays will be further limited to one per condition, consistent with the provisions of paragraph 78.8(3)*"a."* A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph 78.8(3)*"a."* A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered will be payable to the X-ray provider, consistent with the provisions in this paragraph.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.9(249A) Home health agencies. Payment will be approved for medically necessary home health agency services prescribed by a physician, nurse practitioner, clinical nurse specialist, or PA in a plan of home health care provided by a Medicare-certified home health agency.

1. The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

2. The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency will only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at paragraph 78.9(10)*"a"* may be provided in settings other than the member's residence when medically necessary.

3. Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

4. Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) through 78.9(10).

5. Payment will be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

6. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy.

7. Payment may be made for restorative and maintenance home health agency services.

8. Payment may be made for teaching, training, and counseling in the provision of health care services.

9. Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

10. The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

11. Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or PA, evidenced by the physician's, nurse practitioner's, clinical nurse specialist's, or PA's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a PA and the Medicaid member no more than 90 days before or 30 days after the start of service. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.
b. Type of service to be rendered and the treatment modalities being used.
c. Frequency of the services.
d. Assistance devices to be used.
e. Date home health services were initiated.
f. Progress of member in response to treatment.
g. Medical supplies to be furnished.
h. Member's medical condition as reflected by the following information, if applicable:
(1) Dates of prior hospitalization.
(2) Dates of prior surgery.
(3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or PA.
(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
(5) Prognosis.
(6) Functional limitations.
(7) Vital signs reading.
(8) Date of last episode of instability.
(9) Date of last episode of acute recurrence of illness or symptoms.
(10) Medications.
i. Discipline of the person providing the service.
j. Certification period (no more than 60 days).
k. Estimated date of discharge from the hospital or home health agency services, if applicable.

l. Physician's, nurse practitioner's, clinical nurse specialist's, or PA's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or PA before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment will be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services are defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end will be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's, nurse practitioner's, clinical nurse specialist's, or PA's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections will be covered when ordered by a physician, nurse practitioner, clinical nurse specialist, or a PA and included in the plan of care. Other daily skilled nursing visits that are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and will be denied.

a. Skilled nursing services will be evaluated based on the complexity of the service and the condition of the patient.

b. Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment will be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment will be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment will be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment will be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician, nurse practitioner, clinical nurse specialist, or PA. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician, nurse practitioner, clinical nurse specialist, or PA and included in a plan of care will be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

(1) Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

(2) Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

(3) Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services that are not related to patient care are not a covered service if personal care is not rendered during the visit.

(4) For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) Reserved.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children is to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

(1) The potential risk factors,

(2) The medical factor or symptom that verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, hard of hearing, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under will be approved if determined to be medically necessary. Payment will be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services that are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals.

1. Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule will be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

2. Private duty nursing or personal care services do not include:

- Respite care, which is a temporary intermission or period of rest for the caregiver.
- Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
- Services provided to other persons in the member's household.
- Services requiring prior authorization that are provided without regard to the prior authorization process.
- Transportation services.
- Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services will be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals will not be granted for treatment plans that exceed 16 hours of home health agency services per day.

78.9(11) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by Iowa Medicaid.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), PA's, or ARNP's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, PA's, or ARNP's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using an Outpatient Prior Authorization Request form. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item that meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator, with approved medical necessity.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase will be made by Iowa Medicaid and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) for prior authorization requirements.

78.10(2) *Durable medical equipment.* DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. DME in a hospital, nursing facility, or ICF/ID is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an ICF/ID when all of the following requirements and conditions have been met:

1. Medical documentation or a reasonable facsimile is completed by a physician, PA, or ARNP and qualifies the member in accordance with Medicare criteria.
2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.
3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:
   - The initial, periodic and ending reading on the time meter clock on each oxygen system, and
   - The dates of each initial, periodic and ending reading, and
   - Evidence of ongoing need for oxygen services.
4. The maximum Medicaid payment will be based on the least costly method of oxygen delivery.
5. Oxygen prescribed "PRN" or "as necessary" is not payable.
6. Medicaid payment will be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.
7. Payment is not allowed for oxygen services that are not documented according to the department of inspections, appeals, and licensing requirements in 481—Chapter 58.

(2) Speech generating devices with approved medical necessity.

(3) Wheelchairs for members in an ICF/ID.

b. The types of DME covered through the Medicaid program include but are not limited to:

Automated medication dispenser.
Bathtub/shower chair, bench. See subrule 78.10(5) for prior authorization requirements.
Commode, shower commode chair. See subrule 78.10(5) for prior authorization requirements.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See subrule 78.10(5) for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Heat/cold application device.
Hospital bed and accessories.
Inhalation equipment. See subrule 78.10(5) for prior authorization requirements.
Insulin infusion pump. See subrule 78.10(5) for prior authorization requirements.
Lymphedema pump.
Mobility device and accessories. See subrule 78.10(5) for prior authorization requirements.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in paragraphs 78.10(2)*"a"* and *"c."*
Patient lift. See subrule 78.10(5) for prior authorization requirements.
Phototherapy bilirubin light.
Protective helmet.
Seat lift chair.
Speech generating device. See subrule 78.10(5) for prior authorization requirements.
Traction equipment.
Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, PA, or ARNP shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, PA, or ARNP. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, medical documentation, or a reasonable facsimile completed by a physician, PA, or ARNP shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, PA, or ARNP must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, PA, or ARNP of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems will be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed "PRN" or "as necessary" is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;

5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including but not limited to front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;
3. Positioning accessories;
4. Specialized skin protection seat and back cushions; and
5. Anti-rollback devices.

(3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:

1. Lap belt or safety belt;
2. Battery charger, single mode;
3. Complete set of tires/wheels and casters, any type;
4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:

- For standard duty, seat width and/or depth greater than 20 inches;
- For heavy duty, seat width and/or depth greater than 22 inches;
- For very heavy duty, seat width and/or depth greater than 24 inches;
- EXCEPTION: For extra heavy duty, there is no separate billing;

9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:

- For standard duty, seat width and/or depth greater than 20 inches;
- For heavy duty, seat width and/or depth greater than 22 inches;
- For very heavy duty, seat width and/or depth greater than 24 inches;
- EXCEPTION: For extra heavy duty, there is no separate billing;

10. Non-expandable controller or standard proportional joystick (integrated or remote); and
11. All labor charges involved in the assembly of the wheelchair (including but not limited to front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:

1. Shoulder harness/straps or chest straps/vest;
2. Elevating legrest;
3. Angle adjustable footplates;
4. Adjustable height armrests; and
5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

(5) Customized items are payable with a prior authorization, in accordance with 42 CFR 414.224 as amended to July 1, 2026.

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), PA, or ARNP within the scope of

practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

b. The types of prosthetic devices covered through the Medicaid program include but are not limited to:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Enteral delivery supplies and products. See subrule 78.10(5) for prior authorization requirements.

(4) Hearing aids. See rule 441—78.14(249A).

(5) Orthotic devices. See paragraph 78.10(3)*"c"* for limitations on coverage of cranial orthotic devices.

(6) Ostomy appliances.

(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost.

c. Cranial orthotic device. Payment will be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and meets minimum medical necessity requirements.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See subrule 78.10(5) for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.
Hearing aid batteries.
Incontinence products (for members three years of age and older).
Oral nutritional products. See subrule 78.10(5) for prior authorization requirements.
Ostomy appliances and supplies.
Respirator supplies.
Shoes, diabetic.
Surgical supplies.
Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an ICF/ID when prescribed by the physician, PA, or ARNP:

(1) Catheter (indwelling Foley).

(2) Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

(3) Disposable catheterization trays or sets (sterile).

(4) Disposable irrigation trays or sets (sterile).

(5) Disposable saline enemas (e.g., sodium phosphate type).

(6) Ostomy appliances and supplies.

(7) Shoes, diabetic.

78.10(5) *Prior authorization requirements.* Prior authorization pursuant to rule 441—79.9(249A) is required for some medical equipment and supplies. Refer to the department's website for a list of items that require a prior authorization.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26; Editorial change: IAC Supplement 9/2/26]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home, to a nursing facility, or to a mental health access center. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) Iowa Medicaid will determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or is in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements will not be applicable. Approval for transfer will be made by the department prior to the transfer. When such a transfer is made, the following rate schedule will apply:

One patient - normal allowance
Two patients - 3/4 normal allowance per patient
Three patients - 2/3 normal allowance per patient
Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment will be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) *Definitions.*

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a PA, an ARNP, a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

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

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as amended to July 1, 2026, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) *Covered services.*

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and
2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and

7. Social skills.

78.12(3) *Excluded services.*

a. Services that are habilitative in nature are not covered as behavioral health interventions. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered as behavioral health interventions.

78.12(4) *Coverage requirements.* Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) *Approval of plan.* The behavioral health intervention provider shall contact the member's managed care plan for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.13(249A); and

(5) The plan does not exceed six months' duration.

b. Subsequent plans. The member's managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)*"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by subparagraph 78.12(4)*"c"*(3).

78.12(6) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding evidence-based practices in the field.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) *Covered services.* Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

(1) Mileage reimbursement to the member, if the member is the driver.

(2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.

(3) Taxi service.

(4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.

(5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) *Exclusions.* Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to DME providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) *Conditions and limitations on covered services.* Nonemergency medical transportation services are subject to the following limitations and conditions:

a. Member request. When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and
3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

(1) Whether the member owns a vehicle;

(2) Whether a member-owned vehicle is in working mechanical order and is licensed;

(3) Whether the member has a valid driver's license and auto insurance;

(4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and

(5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

(1) The transportation being provided spans the entire meal period;

(2) The one-way distance to or from the medical appointment is more than 50 miles;

(3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and

(4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) *Grievance procedure.* The broker shall establish an internal grievance procedure for members and transportation providers.

a. Members may appeal to the department pursuant to 441—Chapter 2506 as an "aggrieved person."

b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 2506, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)*"b,"* the grievance process shall end with binding arbitration, with a designee of Iowa Medicaid as arbitrator.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.14(249A) Hearing aids. Payment will be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The member shall have an examination by a physician to determine that the member has no condition that would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members

18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department will cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department will make payment for travel to the member's place of residence or other suitable location. The department will make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department will pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.14(249A). The department will pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids will be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department will make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries will be at the current audiologist's fee schedule.

c. Payment for repairs will be made to the dealer for repairs made by the dealer. Payment for in-house repairs will be made at the current fee schedule. Payment will also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs will be at the amount shown on the manufacturer's invoice. Payment will be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, an Examiner Report of Need for a Hearing Aid form shall be submitted along with the forms required by 441—paragraph 79.8(1)*"a."*

(1) Payment for the replacement of a hearing aid less than four years old will require prior approval except when the member is under 21 years of age. The department will approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid.

(2) Payment for a hearing aid costing more than $650 will require prior approval. The department will approve payment for either of the following purposes:

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech

recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.15(249A) Orthopedic shoes. Payment will be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule as amended to July 1, 2026, or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a PA, or an ARNP that includes all of the following:

a. The date.
b. The patient's diagnosis.
c. The reason orthopedic shoes are needed.
d. The probable duration of need.
e. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the International Classification of Diseases (ICD) as amended to July 1, 2026. A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.
(2) Pain.
(3) Tissue breakdown or a high probability of tissue breakdown.
(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology as amended to July 1, 2026, or

(3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed that shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"* (1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department or its designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for member care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225A) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative that provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* through *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—24.1(225A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted

in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—24.1(225A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for member care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall

be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services, including individual, group, and family therapy.

(2) Psychosocial rehabilitation services. Active treatment examples include but are not limited to individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the Diagnostic and Statistical Manual of Mental Disorders as amended to July 1, 2026. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment that reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals that are general statements of member outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered on the "National Register of Health Service Providers in Psychology" as amended to July 1, 2026. Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

(1) The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

(2) Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(3) Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

(4) Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225A) can receive day treatment services under this subrule or subrule 78.16(6).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.17(249A) Physical therapists. Payment will be approved when the services provided relate directly to an active written treatment plan; follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA after any needed consultation with the qualified physical therapist; are reasonable and necessary to the treatment of the patient's illness or injury; and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"b."*

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in rule 441—84.1(249A) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the VFC program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Seven screenings in the first year of life.

(2) Four screenings between the ages of 13 months and 30 months.

(3) One screening per year at ages three, four, five, and six.

(4) One screening per year at ages 7 through 21.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening, the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Reserved.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment will be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an ICF/ID, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections, appeals, and licensing are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will Iowa Medicaid or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an ICF/ID. Physical, occupational, and speech therapy services for residents of the nursing facility, ICF/ID, or hospital are the responsibility of the nursing facility, ICF/ID, or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to subparagraphs 78.19(1)*"b"*(7) and *"b"*(8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes unless an untimed or encounter billing code is used.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to subparagraphs 78.19(1)*"b"*(7) and *"b"*(8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to subparagraph 78.19(1)*"b"*(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist.

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

1. Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

2. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

3. After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

4. When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is

complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals will be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

1. When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

2. At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

3. Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See numbered paragraph "4" below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved unless the reasons that blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

4. The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

- There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)
- Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)
- Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.
- If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.
- For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.
- Documentation should include any previous attempts to resolve problems using nontherapy personnel (residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.
- Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.
- Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions that have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist, and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in subparagraphs 78.19(1)*"b"*(7), *"b"*(8), and *"b"*(16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of subparagraph 78.19(1)*"b"*(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient that require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services that are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis that will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities that are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss or become hard of hearing (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in subparagraphs 78.19(1)*"b"*(7), *"b"*(8), and *"b"*(16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then the fifth paragraph under subparagraph 78.19(1)*"b"*(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to subparagraph 78.19(1)*"b"*(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).

(2) Prior teaching, training, or counseling provided.

(3) The medical necessity of the rendered services.

(4) The identification of specific services and goals.

(5) The date of the start of the services.

(6) The frequency of the services.

(7) Progress in response to the services.

(8) The estimated length of time the services are needed.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program. Payment will be made for sterilization in accordance with subrule 78.1(16).

78.21(1) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.21(2) *Risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.21(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.21(4) *Dental services.* Payment will be made to rural health clinics for dental services payable under Iowa Medicaid's dental wellness plan as described in 441—Chapter 73.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26; **ARC 0767D**, IAB 11/25/26, effective 1/1/27]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with subrule 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the VFC program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, that provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with subrule 78.1(16).

78.23(2) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.23(3) *Risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.23(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist will be made on a fee for service basis.

a. Payment will be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in subrule 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Reserved.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service that does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using a Medicaid Prenatal Risk Assessment form shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a PA, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and PAs performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Reserved.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which will include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board in 481—Chapter 576.

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented on the Medicaid Prenatal Risk Assessment form. An appropriately trained physician or ARNP must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Reserved.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.

(6) Infant care.

(7) Grief support for unhealthy outcome.

(8) Parenting of a preterm infant.

(9) Identification of and referral to community resources as needed.

78.25(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures will be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure will be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by Iowa Medicaid is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from Iowa Medicaid.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through Iowa Medicaid. Payment will only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) *Definitions.*

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Benefits education" means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

"Career exploration," also referred to as "career planning," means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

"Career plan" means a written plan documenting the member's stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state's minimum wage.

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Certified employment specialist" or *"CES"* means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

"Child and Adolescent Level of Care Utilization System" or *"CALOCUS"* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service and intensive residential habilitation services for individuals aged 16 to 18.

"Comprehensive service plan" means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Customized employment" means an approach to supported employment that individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized

employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Individual employment" means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

"Individual placement and support" or *"IPS"* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat as amended to July 1, 2026, and as measured by its employment fidelity scale available online at ipsworks.org as amended to July 1, 2026.

"Integrated community employment" means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and that presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

"Intensive residential service homes" or *"intensive residential services"* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation, home-based habilitation, or HCBS intellectual disability waiver supported community living and meet additional criteria specified in rule 441—77.30(249A) and the provider manual as amended to July 1, 2026.

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"IoWANS" means the department's Institutional and Waiver Authorization and Narrative System.

"Level of Care Utilization System" or *"LOCUS"* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation and intensive residential services for individuals aged 19 and older.

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

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

"Severe and persistent mental illness" or *"SPMI"* means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational, or vocational roles.

"Supported employment" means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce

in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

"Supported self-employment" includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

"Sustained employment" means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria.

a. LOCUS/CALOCUS actual disposition. The member has a LOCUS/CALOCUS actual disposition of level one recovery maintenance and health management or higher on the most current LOCUS/CALOCUS assessment completed within the past 30 days.

b. Risk factors. The member meets at least one of the following risk-based criteria:

(1) The member has a history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the member's life; or

(2) The member has a history of continuous professional psychiatric supportive care other than hospitalization; or

(3) The member has a history of involvement with the criminal justice system; or

(4) Services available in the member's community have not been able to meet the member's needs; or

(5) The member has a history of unemployment or employment in a sheltered setting or poor work history; or

(6) The member has a history of homelessness or is at risk of homelessness.

c. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least 12 months:

(1) The member needs assistance to obtain or maintain employment.

(2) The member requires financial assistance to reside independently in the community.

(3) The member needs significant assistance to establish or maintain a personal social support system.

(4) The member needs assistance with at least one of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to reside independently in the community.

(5) The member needs assistance with management and intervention of maladaptive or antisocial behaviors to ensure the safety of the individual or others.

d. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

e. Needs assessment. The department-approved assessment tool has been completed, and Iowa Medicaid has determined that the member is in need of home- and community-based habilitation services.

f. Designated case manager. The designated case manager shall:

(1) Arrange for the completion of the needs-based assessment before services begin, and annually thereafter, and more frequently if significant observable changes occur in the member's situation, condition, or circumstances.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4) and 441—paragraph 90.4(1)*"b"* before services begin and annually thereafter, and when there is a significant observable change in the member's situation, condition, or circumstances.

g. Plan for service. The department or the member's MCO has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated by Iowa Medicaid or the member's MCO will be considered approved by the department. Home-

and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4) and 441—paragraph 90.4(1)*"b."* A service plan may change when requested by the member or the member's interdisciplinary team when there is a significant observable change in the member's situation, condition, or circumstances.

(2) For members receiving home-based habilitation, the service plan shall include the member's needs-based assessment, actual disposition, the composite score, and each individual domain score for each of the six assessed domains.

(3) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) *Application for services.* The member or case manager shall apply for habilitation services on behalf of a member by contacting Iowa Medicaid. The department will issue a notice of decision to the applicant in accordance with 441—Chapter 16 when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis. The comprehensive service plan will meet the criteria described in the HCBS habilitation manual.

b. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

c. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as detailed in the HCBS habilitation manual.

d. Plan approval. Services shall be entered into IoWANS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through IoWANS will be considered approved by the department. Services must be authorized in IoWANS as specified in paragraph 78.27(2)*"g."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Exclusions. Payment will not be made for case management provided to a member who is eligible for targeted case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living, working, and recreating in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities to address daily living needs;

(3) Assistance with symptom management and participation in mental health treatment;

(4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment;

(5) Assistance with accessing and participating in substance use disorder treatment and services;

(6) Assistance with medication administration and medication management;

(7) Assistance with understanding communication whether verbal or written;

(8) Community inclusion and active participation in the community;

(9) Transportation;

(10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training;

(11) Social and leisure skill development;

(12) Personal care; and

(13) Protective oversight and supervision.

b. Setting requirements. Home-based habilitation services shall occur in the member's home and community.

(1) A member may live in the member's own home, within the home of the member's family or legal representative, or in another community living arrangement that meets the criteria in 441—subrule 77.30(5).

(2) A member living with the member's family or legal representative is not subject to the criteria in 441—paragraphs 77.30(7)*"d"* and *"e."*

(3) A member may not reside in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

c. Home-based habilitation level of service criteria. Home-based habilitation services shall be available to members based on the member's most current LOCUS/CALOCUS actual disposition score, according to the following criteria:

(1) Intensive IV residential habilitation services. Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and

2. The member is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;

(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five.

(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four.

(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I services, the member must have a LOCUS/CALOCUS actual disposition of level three.

(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two.

(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one.

(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level one.

d. Additional criteria for receiving home-based habilitation services for transition-age youth 16 to 18 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Individuals 16 to 18 years of age shall receive 24-hour site supervision and support.

(3) Members residing outside of the family home may receive daily home-based habilitation in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.30(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Individuals under the age of 18 may not reside in settings with individuals over the age of 21.
- The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.
- For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

(4) The member's parent or guardian has consented to home-based habilitation services.

(5) The member is able to pay room and board costs (funding sources may include but are not limited to supplemental security income, child support, adoptions subsidy, or private funds).

(6) Youth under the age of 16 needing daily home-based habilitation outside the family home must receive services in a licensed or certified residential-based supported community living setting.

e. Exclusions. Home-based habilitation payment will not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an ICF/ID.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member's individual goals as identified in the member's comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

(1) Identifying the member's interests, preferences, skills, strengths and contributions,

(2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,

(3) Planning and coordination of the member's individualized daily and weekly day habilitation schedule,

(4) Developing skills and competencies necessary to pursue competitive integrated employment,

(5) Participating in community activities related to hobbies, leisure, personal health, and wellness,

(6) Participating in community activities related to cultural, civic, and religious interests,

(7) Participating in adult learning opportunities,

(8) Participating in volunteer opportunities,

(9) Training and education in self-advocacy and self-determination to support the member's ability to make informed choices about where to live, work, and recreate,

(10) Assistance with behavior management and self-regulation,

(11) Use of transportation and other community resources,

(12) Assistance with developing and maintaining natural relationships in the community,

(13) Assistance with identifying and using natural supports,

(14) Assistance with accessing financial literacy and benefits education,

(15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence. Family training may be provided in the member's home.

e. Duration. Day habilitation services shall be furnished as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

g. Concurrent services. A member's comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment, long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

h. Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment will not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) *Prevocational service habilitation.* "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member

can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,
2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services that lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9)*"a"*(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)*"a"*(1). This time limit can be extended as stated in numbered paragraphs 78.27(9)*"e"*(1)"1" through "6." If the criteria in numbered paragraphs 78.27(9)*"e"*(1)"1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) *Supported employment services.*

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service.

An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)*"a"*(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

b. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual

employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, which allows the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)*"b"*(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development that leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
11. Transportation of the member during service hours.

d. Individual placement and support (IPS).

(1) IPS shall include the following activities, which shall be described and documented in the member's employment plan:

1. Development of the career profile, including previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement, education and plan for graduation.
2. Integration of IPS team members and the behavioral health team, including routine staffing meetings regarding IPS clients.
3. Addressing barriers to employment, which may be actual or perceived. Support may include addressing justice system involvement, a lack of work history, limited housing, child care, and transportation.
4. Rapid job search and systematic job development. Community and employment supports (CESs) help members seek jobs directly and do not provide extensive preemployment assessment and training or intermediate work experiences. The job process begins within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers' needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.
5. Disclosure counseling, to assist the member in making an informed decision on disclosure of a disability to a prospective or current employer.
6. Identification and implementation of job accommodations and assistive technology supports.

7. Ongoing benefits counseling. The member must receive information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.

8. Time-unlimited follow-along supports. These supports are planned for early in the employment process, are personalized, and follow the member for as long as the member needs support. The focus is supporting the member in becoming as independent as possible and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

(2) Units of service. Reimbursement is made for each outcome achieved for the member participating in the IPS supported employment model. Outcomes are as follows:

1. Outcome #1: Completed employment plan.
2. Outcome #2: First day of successful job placement.
3. Outcome #3: 45 days successful job retention.
4. Outcome #4: 90 days successful job retention.

e. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

f. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed the cost limitations published on the Iowa Medicaid fee schedule webpage.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

g. Exclusions. Supported employment services payments will not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq. as amended to July 1, 2026). Documentation that the service is not available to the individual under

these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) *Adverse service actions.*

a. Denial. Services will be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department will issue a notice of decision pursuant to 441—Chapter 16 to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision will be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action pursuant to 441—Chapter 16 and the right to appeal in accordance with 441—Chapter 2506. The member is entitled to have a review of the determination of needs-based eligibility or of the actual disposition score by sending

a letter requesting a review to Iowa Medicaid at the department's address. If dissatisfied with that decision, the member may file an appeal with the department.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, PA, or ARNP that are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Reserved.

c. Enteral products and enteral delivery pumps and supplies. Payment will be approved pursuant to the criteria in subrule 78.10(5).

d. Reserved.

e. Speech generating device. Payment will be approved pursuant to the criteria in subrule 78.10(5).

f. Preprocedure review by Iowa Medicaid will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures that have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by Iowa Medicaid will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department. If not approved by Iowa Medicaid, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from Iowa Medicaid.

g. Enclosed beds. Payment will be approved pursuant to the criteria in subrule 78.10(5).

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria.

i. Oral nutritional products. Payment will be approved pursuant to the criteria in subrule 78.10(5).

j. Vest airway clearance system. Payment will be approved pursuant to the criteria in subrule 78.10(5).

k. DME rebate agreements. Payment will be approved pursuant to the criteria in subrule 78.10(5).

l. Reimbursement over the established Medicaid fee schedule amount. Payment will be approved pursuant to the criteria in subrule 78.10(5).

m. Bathtub/shower chair, bench. Payment will be approved pursuant to the criteria in subrule 78.10(5).

n. Patient lift, nonstandard. Payment will be approved pursuant to the criteria in subrule 78.10(5).

o. Power wheelchair attendant control. Payment will be approved pursuant to the criteria in subrule 78.10(5).

p. Shower commode chair. Payment will be approved pursuant to the criteria in subrule 78.10(5).

q. Ventilator, secondary. Payment will be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs, subject to the requirements of paragraph 78.10(2)*"d."*

78.28(2) Notwithstanding the provisions of paragraph 78.28(1)*"a,"* under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

a. Buprenorphine,

b. Buprenorphine and naloxone combination,

c. Methadone,

d. Naltrexone, and

e. Naloxone.

For the purpose of this subrule, "medication-assisted treatment" means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services requiring prior approval are outlined in the Iowa Medicaid Dental Provider Manual as amended to July 1, 2026.

78.28(4) Optometric services and ophthalmic materials that must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment will be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include but are not limited to hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval will be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval will be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient pursuant to rule 441—78.7(249A) and subrule 78.1(18).

78.28(5) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department will approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid.

b. A hearing aid costing more than $650. The department will approve payment for either of the following purposes:

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services requiring prior approval, preprocedure review or preadmission review are outlined in the Acute Hospitals Provider Manual as amended to July 1, 2026.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as set forth in the Ambulatory Surgical Centers Provider Manual as amended to July 1, 2026.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval will be granted if ACT services are determined to be medically necessary. Approval will be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and will be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and will be approved if determined to be medically necessary. Payment will be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and that are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, ICFs/ID, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services will be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and will be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals will not be granted for treatment plans that exceed 16 hours of home health agency services per day.

78.28(11) Replacement of vibrotactile aids less than four years old will be approved when the original aid is broken beyond repair or lost.

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12)*"b,"* the following radiology procedures require prior approval:

(1) Magnetic resonance imaging (MRIs);

(2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;

(3) Computed tomographic angiographs (CTAs);

(4) Positron emission tomography (PETs); and

(5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12)*"a,"* prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) A radiology procedure is ordered or requested by the department, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.10(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on an Outpatient Prior Authorization Request form and approved before any claim for payment is submitted.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.29(249A) Behavioral health services. Payment will be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment will be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services as outlined in the Birth Centers Provider Manual as amended to July 1, 2026.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital. Hospitals with alternate sites approved by the department of inspections, appeals, and licensing are acceptable sites. All outpatient services listed in paragraphs 78.31(1)*"g"* through *"m"* are subject to a random sample retrospective review for medical necessity by Iowa Medicaid. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs 78.31(1)*"a"* through *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs 78.31(1)*"g"* through *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.

b. Outpatient surgery.

c. Laboratory, X-ray and other diagnostic services.

d. General or family medicine.

e. Follow-up or after-care specialty clinics.

f. Physical medicine and rehabilitation.

g. Substance use disorder.

h. Eating disorders.

i. Cardiac rehabilitation.

j. Mental health.

k. Pain management.

l. Diabetic education.

m. Pulmonary rehabilitation.

n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs 78.31(2)*"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Vaccines. In order to be paid for the outpatient administration of a vaccine covered under the VFC program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) *Application for certification.* Hospital outpatient programs listed in paragraphs 78.31(1)*"g"* through *"m"* must submit an application to Iowa Medicaid for certification before payment will be made. Iowa Medicaid will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Substance use disorder.

(1) Approval by joint commission. In addition to certification by the department, substance use disorder programs must also be approved by the joint commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, sex, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups including but not limited to learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance use counselor certified by the Iowa board of certification. Psychiatric

consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted that shall include:

1. A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.
2. A comprehensive medical history and physical examination including the history of physical problems associated with dependence.
3. Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.
4. Any history of physical abuse.
5. A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.
6. A determination of current and past psychiatric and psychological abnormality.
7. A determination of any degree of danger to self or others.
8. The family's history of substance use disorders.
9. The patient's educational level, vocational status, and job performance history.
10. The patient's social support networks, including family and peer relationships.
11. The patient's perception of the patient's strengths, problem areas, and dependencies.
12. The patient's leisure, recreational, or vocational interests and hobbies.
13. The patient's ability to participate with peers and in programs and social activities.
14. Interviews of family members and significant others as available with the patient's written or verbal permission.
15. The patient's legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

1. Alcohol or drugs taken in greater amounts over a longer period than the person intended.
2. Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.
3. Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.
4. Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.
5. Characteristic withdrawal symptoms.
6. Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient, there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall include documentation of:

1. The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs.
2. The patient's participation in the development of the treatment plan.
3. Changes in treatment.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care that meets the following requirements:

1. The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.
2. The plan is in accordance with the patient's reassessed needs at the time of transfer.

3. The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

4. The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

5. Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level. If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

1. A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

2. A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

3. A history of exercise behavior, including type, frequency, and duration.

4. A complete history of current alcohol and other drug use.

5. Any suicidal thoughts or attempts.

6. Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

7. History of experiencing physical or sexual (incest or rape) abuse.

8. History of other counseling experiences.

9. Appropriate psychological assessment, including psychological orientation to the above questions.

10. A medical history, including a physical examination, covering the information listed in subparagraph 78.31(4)*"b"*(4).

11. Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

12. The patient's social support networks, including family and peer relationships.

13. The patient's educational level, vocational status, and job or school performance history, as appropriate.

14. The patient's leisure, recreational, or vocational interests and hobbies.

15. The patient's ability to participate with peers and programs and social activities.

16. Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

17. Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the DSM (Diagnostic and Statistical Manual of Mental Disorders as amended to July 1, 2026) published by the American Psychiatric Association. In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred. The need for treatment may be further substantiated by substance use, out-of-control spending, incidence of stealing to support habit, or compulsive gambling. The symptoms shall have been present for at least six months and three of the following criteria must be present:

1. Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).
2. Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.
3. Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.
4. Gastrointestinal factors including sore throats, Mallory-Weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.
5. Hematologic considerations including anemia, leukopenia, or thrombocytopenia.
6. Ear, nose, and throat factors including headaches or dizziness.
7. Skin considerations including lanugo or dry skin.
8. Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient, there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall document:

1. The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs.
2. The patient's participation in the development of the treatment plans.
3. Changes in treatment.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance use patients in subparagraph 78.31(4)*"a"*(7).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

1. At least one physician, ARNP, or PA responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician, ARNP, or PA must be trained and certified at least to the level of basic life support.

2. A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

3. A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

4. A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

5. A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

6. A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

1. Postmyocardial infarction (within three months postdischarge).
2. Postcardiac surgery (within three months postdischarge).
3. Poststreptokinase.
4. Postpercutaneous transluminal angioplasty (within three months postdischarge).
5. Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

1. Referral form.
2. Physician's orders.
3. Laboratory reports.
4. Electrocardiogram reports.
5. History and physical examination.
6. Angiogram report, if applicable.
7. Operative report, if applicable.
8. Preadmission interview.
9. Exercise prescription.
10. Rehabilitation plan, including participant's goals.
11. Documentation for exercise sessions and progress notes.
12. Nurse's progress reports.
13. Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral. The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—24.1(225A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, including:

1. A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.
2. A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.
3. Any history of physical abuse.
4. A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.
5. A determination of current and past psychiatric and psychological abnormality.
6. A determination of any degree of danger to self or others.

7. The family's history of mental health problems.
8. The patient's educational level, vocational status, and job performance history.
9. The patient's social support network, including family and peer relationship.
10. The patient's perception of the patient's strengths, problem areas, and dependencies.
11. The patient's leisure, recreational or vocational interests and hobbies.
12. The patient's ability to participate with peers in programs and social activities.
13. Interview of family members and significant others, as available, with the patient's written or verbal permission.
14. Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type that cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.

4. Activity therapies that are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

- Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.
- Service components may include individual and group therapy, reality orientation, stress management and medication management.
- Services are provided for a period for four to eight hours per day.
- Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.
- Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.
- Services are structured with an emphasis on program variation according to individual need.
- Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered, except as indicated:

1. Activity therapies, group activities, or other services and programs that are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

2. Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

3. Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

1. The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.
2. The person must be free of any underlying psychosis or severe neurosis.
3. The person cannot be toxic on any addictive drugs.
4. The person must be capable of self-care, including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the

assessment and specifies the times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The plan shall document:

1. The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs.
2. The patient's participation in the development of the treatment plan.
3. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care that meets the following requirements:

1. The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.
2. The plan is in accordance with the patient's reassessed needs at the time of transfer.
3. The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.
4. The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) General characteristics. An outpatient diabetes self-management education program shall provide instruction that will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(2) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(3) Admission criteria. Candidates for the program shall meet the following guidelines:

1. The person must have Type I or Type II diabetes.
2. The person must be referred by the attending physician.
3. The person shall demonstrate an ability to follow through with self-management.

(4) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(5) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines that must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

1. A diagnostic workup that entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

2. Behavioral considerations, including an emotional screening assessment and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD); having cardiac stability and social, family, and financial resources; having the ability to tolerate periods of sitting time; and being a nonsmoker for six months or, if a smoker, willingness to quit and having a physician's order to participate anyway. Factors that would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed to determine current clinical problems, needs, and responses to treatment. The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase. Changes in treatment must be documented. Components of pulmonary rehabilitation to be included are:

1. Physical therapy and relaxation techniques,
2. Exercise conditioning or physical conditioning for those with exercise limitations,
3. Respiratory therapy, education, an emphasis on the importance of smoking cessation, and
4. Nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are eligible to receive services under the HCBS intellectual disability waiver or children's mental health waiver.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. For the purposes of this rule, "HCBS Provider Manual" means the department's manual that outlines provider-specific policies applicable to providers of HCBS services. The manual is available on the department's website. All references to the HCBS Provider Manual herein are as amended to July 1, 2026.

78.34(1) *Home maintenance support services.* Home maintenance support services encompass assistance required to maintain the participant's home as a clean, sanitary, and safe environment, provided when neither the participant nor any household person is capable of performing these tasks and no other relative, caregiver, or landlord is responsible for them. These services are particularly essential when the participant lives alone or when the usual caregiver needs support in performing these functions. "Usual caregiver" means an unpaid person who resides with the member and is available on a 24-hour per-day basis to assume responsibility for the care of the member.

a. These may involve tasks such as:

(1) Essential shopping, such as shopping for basic need items such as food, clothing or personal care items, or drugs.

(2) Limited housecleaning, such as maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and washing dishes.

(3) Window and door maintenance, such as hanging screen windows and doors, replacing window panes, and washing windows.

(4) Minor repairs to walls, floors, stairs, railings, and handles.

(5) Heavy cleaning, such as cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal.

(6) Mowing lawns and removing snow and ice from sidewalks and driveways.

(7) Tree or bush trimming when the tree or bush impairs safe navigation of the exterior of the home.

(8) Pest eradication and one-time cleaning following the pest eradication necessary for the person's health and safety.

b. Excluded services and costs. Services, activities, costs, and time that are not covered include but are not limited to:

(1) Tree trimming.

(2) Trash burning.

(3) Tree removal.

78.34(2) *Home health aide services.* Home health aide services are an extension of the state plan and are personal or direct care services provided to the member in the member's home that are not otherwise payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. A visit is defined as 15 minutes to 120 minutes.

a. Components of the service include but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a member with bath, shampoo, or oral hygiene.

(3) Helping a member with toileting.

(4) Helping a member in and out of bed and with ambulation.

(5) Helping a member reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician that are ordinarily self-administered.

(7) Performing incidental household services that are essential to the member's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.*

a. Supports provided during day care are protective oversight, supervision, and support with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Included are personal care (i.e., ambulation, toileting, feeding, assisting with medications), behavioral support, or intermittent health-related cares not otherwise paid under other waiver or state plan programs.

b. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day).

78.34(4) *Nursing care services.* Nursing care services are services that are included in the plan of treatment approved by the physician and that are provided by licensed nurses to members in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is an attendant care or supported community living provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health and substance use disorder services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225A) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the

number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Attendant care service.* Attendant care services are service activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7)*"f"* and the skilled activities listed in paragraph 78.34(7)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date an HCBS Attendant Care Agreement to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of attendant care as allowed by 441—paragraph 79.10(7)*"b,"* the following apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled attendant care services shall be provided under the supervision of the member's physician or a licensed nurse or licensed therapist working under the direction of the member's physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Attendant Care Service Record or use a form prescribed by the department. Any service component that is not documented in accordance with rule 441—79.3(249A) will not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled attendant care service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including but not limited to bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting for medical needs that make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school or work setting.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school or work.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost will be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf or hard of hearing.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment will be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

i. Payment for home and vehicle modifications are limited to the service limitations published on the Iowa Medicaid fee schedule webpage.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year will be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year will be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academies of Sciences, Engineering, and Medicine. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The CCO is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13)*"g"* and employer authority tasks identified in paragraph 78.34(13)*"h,"* or who delegates the budget or employer authority tasks identified in paragraph 78.34(13)*"i."* Components of this service are set forth below.

a. Agreement. As a condition of participating in the CCO, a member shall sign the HCBS Consumer Choices Informed Consent and Risk Agreement to document that the member has been informed of the responsibilities and risks of electing the CCO.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability, elderly, AIDS/HIV, brain injury, and physical disability waivers are outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026.

(2) The department will determine an average unit cost for each service outlined in the HCBS Provider Manual based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department will apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department will compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor will be no lower than 60 percent.

(5) Individual budgets for respite services will be computed based on the average cost for services outlined in the HCBS Provider Manual. Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).

(6) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by Iowa Medicaid or the MCO as the least costly option to meet the member's need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member's service plan and authorized by the case manager or community-based case manager.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the CCO, a member must choose to hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the CCO may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and

community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Items and services not covered by the individual budget are outlined in the HCBS Provider Manual.

(4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by Iowa Medicaid or the member's MCO. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment as outlined in the HCBS Provider Manual.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)*"d."* The savings plan shall meet the requirements in paragraph 78.34(13)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's MCO for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or MCO to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13)*"i."*

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

(1) Recruit and hire employees.
(2) Verify employee qualifications.
(3) Specify additional employee qualifications.
(4) Determine employee duties.
(5) Determine employee wages and benefits.
(6) Schedule employees.
(7) Train and supervise employees.

i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent

or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)*"g"* and employer authority tasks identified in paragraph 78.34(13)*"h."* Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.

(4) The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the CCO shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455 as amended to July 1, 2026. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act as amended to July 1, 2026, and is not eligible to receive federal funds.

(4) For personal care services, employees shall use an electronic visit verification system that captures all documentation requirements of the Consumer Choices Option Semi-Monthly Time Sheet or use a form prescribed by the department. All other employees shall complete, sign and date the Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. All employees shall maintain documentation that complies with rule 441—79.3(249A).

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13)*"m"*(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) *General service standards.* All health and disability waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.35(249A) Occupational therapist services. Payment will be approved for the services provided by an occupational therapist that follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or PA; are reasonable and necessary to the treatment of the patient's illness or injury; and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in paragraphs 78.19(1)*"a"* and *"c."*

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) as amended to July 1, 2026, for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A) as amended to July 1, 2026, including an individual who is not enrolled in a Part D plan.

(7) Home maintenance support and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) Curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care that is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Home maintenance support and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's

record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, the Election of Medicaid Hospice Benefit form, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. A Revocation of Medicaid Hospice Benefit form is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.37(2) *Personal emergency response or portable locator system.* A personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Home maintenance support services.* Home maintenance support services are activities provided pursuant to subrule 78.34(1).

78.37(5) *Nursing care services.* Nursing care services are an extension of the State Plan, are included in the plan of treatment approved by the physician, and are provided by licensed agency nurses to members in the home or community. The services are reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the board of nursing. A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are service activities provided pursuant to subrule 78.34(5).

78.37(7) *Home-delivered meals.* Home-delivered meals are meals provided pursuant to subrule 78.34(11).

78.37(8) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.37(9) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(10) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.37(11) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.37(12) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the member is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the member during a month when the member is enrolled.

78.37(13) *Assisted living service.* The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living

service is not reimbursable if performed at the same time as any service included in an approved attendant care agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized attendant care service.

78.37(14) *General service standards.* All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process detailed in paragraph 78.31(14)*"e"* will apply.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225A) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Home maintenance support services.* Home maintenance support services are service activities provided pursuant to subrule 78.34(1).

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided pursuant to subrule 78.34(5).

78.38(6) *Home-delivered meals.* Home-delivered meals are meals provided pursuant to subrule 78.34(11).

78.38(7) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.38(8) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.38(9) *CCO.* The CCO are service activities provided pursuant to subrule 78.34(13).

78.38(10) *General service standards.* All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.39(249A) Federally qualified health centers. Payment will be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act as amended to July 1, 2026.

78.39(1) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, federally qualified health centers, other clinics, and emergency rooms.

78.39(2) *Risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment form, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

78.39(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.40(249A) ARNPs. Payment will be approved for services provided by ARNPs within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment will be made to ARNPs directly, without regard to whether the ARNP is employed by or associated with a physician, hospital, birth center, clinic, or other health care provider recognized under state law. An established protocol between a physician and the ARNP will not

cause an ARNP to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment will be approved for services rendered in any location in which the ARNP is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review will be conducted for Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, ARNPs, other clinics, and emergency rooms.

78.40(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the VFC program, an ARNP must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) *Prenatal risk assessment.* Risk assessment, using a Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services described in subrule 78.25(3).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal care services, home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities that assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities that assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities that assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities that assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities that assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

(3) Intensive residential services are supported community living services provided 24 hours per day to members with a serious and persistent mental illness diagnosis residing in a designated intensive residential service home. To be eligible for supported community living intensive residential services, the member must meet the eligibility criteria in paragraph 78.27(7)*"c."*

(4) Supported community living services delivered through the remote supports modality must meet the requirements pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026.

(5) Supported community living services delivered in a host home by a subcontractor of the supported community living services agency must meet the requirements pursuant to HCBS Waiver Provider Manual as amended to July 1, 2026.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Additional criteria for receiving supported community living services for transition-age youth 16 to 18 years of age.

(1) Members residing in the family home may receive supported community living services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside of the family home may receive daily supported community living in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.30(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Members 16 to 18 years of age shall receive 24-hour site supervision and support.
- Members under the age of 18 may not reside in settings with individuals over the age of 21.
- The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.
- For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

3. The member's parent or guardian has consented to supported community living services.

4. The member is able to pay room and board costs (funding sources may include but are not limited to supplemental security income, child support, adoptions subsidy, or private funds).

f. Youth under the age of 16 needing supported community living outside the family home must receive services in a licensed or certified residential-based supported community living setting.

g. Maintenance and room and board costs are not reimbursable.

h. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures.

i. A unit of service is:

(1) One full calendar day when a member receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)*"i"*(1) does not apply.

j. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year, except a leap year, when 366 daily units are available.

(2) 20,440 15-minute units per state fiscal year, except a leap year, when 20,496 15-minute units are available.

k. The service shall be identified in the member's service plan.

l. Supported community living services will not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the waiver.

78.41(2) *Respite care services.* Respite care services are services provided pursuant to subrule 78.34(5).

78.41(3) *Personal emergency response or portable locator system.* The personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.41(4) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the member's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member that are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.41(9) *IMMT services.* IMMT services are activities performed pursuant to subrule 78.34(8).

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a certified residential-based supported community living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or assist in developing self-help skills for maximum independence.

a. Allowable service components are:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.40(11)*"d."*

f. Residential-based supported community living services will not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day. A day is 24 hours of supervision and support.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation.* Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.42(249A) Pharmacists providing covered vaccines. When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) *Vaccines administered to children.* Payment will be made to an enrolled provider for an administration fee for vaccines available through the VFC program administered by the department if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) *Vaccines administered to adults.* Payment will be made to an enrolled provider for an administration fee and vaccine cost.

78.42(3) *Verification and reporting.* Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.43(249A) HCBS brain injury waiver services. Payment will be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of members and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the member to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the member so that the abilities, needs and desires of the member can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual members.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community according to the individualized member need as identified in the service plan.

a. The basic components of the service may include but are not limited to personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities that assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities that assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities that assist a member to maintain or develop skills necessary to sustain the member in the physical environment and that are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities that assist a member to develop or maintain skills that include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities that assist a member to develop or maintain skills, including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary

responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and that are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1,570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)*"e"*(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is an attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.43(6) *Personal emergency response or portable locator system.* A personal emergency response or portable locator system are services provided pursuant to subrule 78.34(10).

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment includes medically necessary items that are for personal use by members with a brain injury and that:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service not to exceed the service limitations published on the Iowa Medicaid fee schedule webpage.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items will be based on a fee schedule. The amount of the fee will be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services are activities provided pursuant to subrule 78.34(3).

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the member and the family with whom the member lives, or who routinely provide care to the member to increase the member's or family members' capabilities to maintain and care for the member in the community. Counseling may include helping the member or the member's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimens as specified in the individual treatment plan. Periodic training updates may be necessary to safely maintain the member in the community.

Family may include spouse, children, friends, or in-laws of the member. Family does not include individuals who are employed to care for the member.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors which have interfered with the member's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the individual treatment plan.

78.43(13) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.43(14) *IMMT services.* IMMT services are activities performed pursuant to subrule 78.34(8).

78.43(15) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.43(16) *General service standards.* All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.44(249A) Lead inspection services. Payment will be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) *Applicability.* ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the DSM, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary

diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) *Services.* The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, ARNP, or PA.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, ARNP, or PA to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance use. This service consists of direct counseling for treatment of mental health and substance use symptoms by a psychiatrist, licensed mental health professional, ARNP, PA, or substance use specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance use counselor, peer specialist, community support specialist, ARNP, or PA.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance use counselor, peer specialist, community support specialist, ARNP, or PA. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance use counselor, community support specialist, case manager, ARNP, or PA, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance use counselor, community support specialist, case manager, ARNP, or PA. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.46(249A) Physical disability waiver service. Payment will be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) *Attendant care service.* Attendant care services are service activities performed pursuant to subrule 78.34(7).

78.46(2) *Home and vehicle modification.* Covered home or vehicle modifications are activities provided pursuant to subrule 78.34(9).

78.46(3) *Personal emergency response or portable locator system.* A personal emergency response or portable locator are services provided pursuant to subrule 78.34(10).

78.46(4) *Specialized medical equipment.* Specialized medical equipment are provided pursuant to subrule 78.43(8).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) *CCO.* The CCO is service activities provided pursuant to subrule 78.34(13).

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the VFC program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment will be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the department, Iowa child health specialty clinics, and the department of education.

78.49(1) *Covered services.* Covered services include but are not limited to audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) *Case management services.* Payment will also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 as amended to July 1, 2026, or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee will determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child's history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

(4) Completing documentation of the information gathered and the assessment results; and

(5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

(1) Include the child's strengths and preferences;

(2) Consider the child's physical and social environment;

(3) Specify goals of providing services to the child; and

(4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;
(2) The dates of case management services;
(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

b. The infant and toddler program provider shall sign and return a Medicaid Billing Remittance form along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.50(249A) Local education agency services. Subject to the following subrules, payment will be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include but are not limited to audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the VFC program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies will be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act as amended to July 1, 2026, payment for transportation between home and school is not a covered service.

78.50(2) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(3) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

b. The local education agency provider shall sign and return a Medicaid Billing Remittance form along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.51(249A) Indian health service 638 facility services. Payment will be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.47(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Payment will only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) *General service standards.* All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement will not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.30(4).

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the rounding process outlined in paragraph 78.34(14)*"e"* will apply.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items will be based on a fee schedule. The amount of the fee will be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225A) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1,500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager will maintain a signed statement that potential community resources are unavailable and will list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided pursuant to subrule 78.34(5).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.53(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act as amended to July 1, 2026 (Medicare).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.54(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 481—655.9(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.55(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.55(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" are provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's individual needs.

78.55(2) *Member eligibility.* To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment as amended to July 1, 2026, completed by a qualified trained assessor. The assessment of need shall document the member's need for community-based neurobehavioral rehabilitation, and Iowa Medicaid or the member's MCO has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance use.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.55(3) *Covered services.*

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections, appeals, and licensing; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an ICF/ID, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLs;

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

(8) Health and wellness management including dietary and nutritional programming;

(9) Progressive physical strengthening, fitness and retraining;

(10) Assistance with obtaining and use of assistive technology;

(11) Sobriety support development;

(12) Assistance with the self-identification of antecedent triggers;

(13) Assistance with preparation for transition to less intensive services including accessing the community;

(14) Flexibility in programming to meet individual needs;

(15) Assistance with re-learning coping and compensatory strategies;

(16) Support and assistance in seeking substance use and co-occurring disorders services;

(17) Support and assistance with obtaining legal consultation and services;

(18) Assistance with community accessibility and safety;

(19) Assistance with re-learning household maintenance;

(20) Assistance with recreational and leisure skill development;

(21) Assistance with the development and application of self-advocacy skills to navigate the service system;

(22) Opportunities to learn about brain injury and individual needs following brain injury;

(23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(24) Assistance with pursuit of education and employment goals;

(25) Protective oversight in the residential setting and community;

(26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;

(27) Transitional support and training;

(28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;

(29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

(1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Compensatory strategies to assist in managing ADLs;

(4) Behavioral supports;

(5) Assistance with obtaining and use of assistive technology;

(6) Assistance with the self-identification of antecedent triggers;

(7) Flexibility in programming to meet the member's individual needs;

(8) Assistance with re-learning coping and compensatory strategies;

(9) Assistance with the development and application of self-advocacy skills to navigate the service system;

(10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;

(12) Transitional support and training;

(13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to Iowa Medicaid for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to Iowa Medicaid.

(1) Iowa Medicaid will approve the provider's treatment plan if:

1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);

2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;

3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and

5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. Iowa Medicaid may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.55(4) and to the conditions pursuant to subrule 78.55(3).

g. Quality review. Iowa Medicaid may perform the quality review to evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member;

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

(8) The provider's compliance with standards listed in rule 441—77.53(249A).

78.55(4) *Medical necessity.* Nothing in this rule will be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

78.55(5) *Documentation standards.* Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.56(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.56(1) Nursing services are services that are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.56(2) Personal care services are those services that are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care

services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.56(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.56(4) Developmental therapies are those services that are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.56(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.56(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.56(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

(1) Place of service.
(2) Type of service to be rendered and the treatment modalities being used.
(3) Frequency of the services.
(4) Assistance devices to be used.
(5) Date on which services were initiated.
(6) Progress of member in response to treatment.
(7) Medical supplies to be furnished.
(8) Member's medical condition as reflected by the following information, if applicable:

1. Dates of prior hospitalization.
2. Dates of prior surgery.
3. Date last seen by a primary care provider.
4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
5. Prognosis.
6. Functional limitations.
7. Vital signs reading.
8. Date of last episode of acute recurrence of illness or symptoms.
9. Medications.

(9) Discipline of the person providing the service.

(10) Certification period.

(11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.

(12) The appropriate department form is utilized during the prior authorization review.

78.56(7) Nursing, personal care, and psychosocial services do not include:

a. Services provided to members aged 21 and older.

b. Services that require prior authorizations that are provided without regard to the prior authorization process.

c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).

d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).

e. Transportation services.

f. Services provided to a member while the member is in institutional care.

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.57(249A) Qualified Medicare beneficiary (QMB) provider services.

78.57(1) *Payment.* Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.57(2) *Definitions.*

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Medicare cost sharing" means the Medicare member's responsibility for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

"Qualified Medicare beneficiary" or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)*"a."* Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums, coinsurance, copayment, and deductible (except for Part D).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.58(249A) Health insurance premium payment (HIPP) provider services.

78.58(1) *Reimbursement.* A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.58(2) *Definitions.*

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Cost sharing" means the member's health insurance in-network responsibility for a covered service. "Cost sharing" includes coinsurance, copayments, and deductibles.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Eligible member" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"Health insurance premium payment program" or *"HIPP program"* has the same meaning as provided in rule 441—75.21(249A).

[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.59(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.54(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24.
[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

441—78.60(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.
[**ARC 0315D**, IAB 5/27/26, effective 7/1/26]

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◊ Two or more ARCs

1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

3 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

7 July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

8 May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

1 July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.

1 March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

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

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. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" or "MCO" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

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 unit 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 on July 1 of each year.

There are some variations in this methodology that are applicable to certain providers. These are set forth below in subrules 79.1(3) through 79.1(8) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website.

d. Reserved.

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 based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers that 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.

(2) The prospective rates paid established providers that 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.

(3) 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 pursuant to paragraph 79.1(15)*"f."*

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 will be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h"* for more information.

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.47(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, as amended to July 1, 2026. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which will constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which will constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy 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.

i. Inflation factor. When the department's reimbursement methodology for any provider includes an inflation factor, this inflation factor will not exceed the amount by which the consumer price index for all urban consumers increased during the most recent calendar year.

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 6/30/13 plus 1%
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10% Air ambulance: Fee schedule in effect 7/1/21
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%

Provider category	Basis of reimbursement	Upper limit
Applied behavior analysis	Fee schedule	Fee schedule in effect 7/1/22
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/22
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Clinics	Fee schedule	Maximum physician reimbursement rate
Community-based neurobehavioral rehabilitation services	Fee schedule. See 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: $21.11 per 15-minute unit
Community mental health centers	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) as amended to July 1, 2026, 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 an MCO, reimbursement from the MCO will 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.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and health and disability waivers: Fee schedule	Effective 7/1/24, for AIDS/HIV, brain injury, elderly, and health and disability waivers: Provider’s rate in effect 6/30/24 plus 4.1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/24 rate: Veterans Administration contract rate or $1.64 per 15-minute unit, $26.37 per half day, $52.51 per full day, or $78.73

Provider category	Basis of reimbursement	Upper limit
		per extended day if no Veterans Administration contract
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/24, for intellectual disability waiver: The provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute or half-day rate. If no 6/30/24 rate, $2.21 per 15-minute unit or $35.14 per half day. For daily services, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30)
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: Initial one-time fee: $58.48. Ongoing monthly fee: $45.48
Portable locator system	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: Initial one-time fee: $58.48. Ongoing monthly fee: $45.48
3. Home health aides	Fee schedule	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1% or maximum Medicaid rate in effect 6/30/24 plus 4.1%
		For intellectual disability waiver effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1% or maximum Medicaid rate in effect 6/30/24 plus 4.1%, converted to an hourly rate
4. Homemakers	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: $5.84 per 15-minute unit
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%. If no 6/30/24 rate: $98.87 per visit
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: Lesser of maximum Medicare rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, or maximum Medicaid rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, not to exceed $356.93 per day
Basic individual respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: Lesser of maximum Medicare rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate, or maximum Medicaid rate in effect 7/31/25 plus 0.9%, converted to

Provider category	Basis of reimbursement	Upper limit
		a 15-minute rate, not to exceed $356.93 per day
Group respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93 per day
Home care agency:		
Specialized respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $10.15 per 15-minute unit, not to exceed $356.93 per day
Basic individual respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $5.41 per 15-minute unit, not to exceed $356.93 per day
Group respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93 per day
Nonfacility care:		
Specialized respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $10.15 per 15-minute unit, not to exceed $356.73 per day
Basic individual respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/22 rate: $5.41 per 15-minute unit, not to exceed $356.93 per day
Group respite	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93 per day
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93 per day
Nursing facility	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93 per day
Camps	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93 per day
Adult day care	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93
Intermediate care facility	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-

Provider category	Basis of reimbursement	Upper limit
for persons with an intellectual disability		minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93
Foster group care	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93
Child care facilities	Fee schedule	Effective 8/1/25, provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.94 per 15-minute unit, not to exceed $356.93
7. Chore service	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: $5.84 per 15-minute unit
8. Home-delivered meals	Fee schedule	$9.11 per meal. Home-delivered liquid supplement meals are two cans per meal.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver: $1,192.44 lifetime maximum For intellectual disability waiver: $5,962.19 lifetime maximum For brain injury, health and disability, and physical disability waivers 7/1/22: $7,154.65 per year
10. Mental health outreach providers	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/242 plus 4.1%. If no 6/30/24 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year
11. Transportation	Fee schedule	Fee schedule in effect 7/1/24
12. Nutritional counseling	Fee schedule	Effective 7/1/24 for non-county contract: Provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: $9.85 per 15-minute unit
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/24: $1,294.93 per unit
14. Senior companion	Fee schedule	Effective 7/1/24 for non-county contract: Provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: $2.12 per 15-minute unit
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/22 rate: $6.02 per 15-minute unit, not to exceed $139.18 per day
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/22 rate: $6.02 per 15-minute unit, not to exceed $139.18 per day
16. Counseling:		
Individual	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.15%, converted to a 15-

Provider category	Basis of reimbursement	Upper limit
		minute rate. If no 6/30/24 rate: $12.87 per 15-minute unit
Group	Fee schedule	First 30 minutes: effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: $25.74 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group
		Each additional 15 minutes: effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1% converted to a 15-minute rate. If no 6/30/4 rate: $12.86 per 15-minute unit. Rate is divided by the actual number of persons who comprise the group
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/24, provider's rate in effect 6/30/24 plus 4.1%
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/22: $11.59 per 15-minute unit; $565.02 daily
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/24: $11.59 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30)
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed $3,692.34 per month
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed $3,692.34 per month
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/24. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,692.34 per month
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/24, $7,154.64 per year
21. Behavioral programming	Fee schedule	Effective 7/1/24, $12.87 per 15 minutes
22. Family counseling and training	Fee schedule	Effective 7/1/24, $12.86 per 15-minute unit
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/24
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Fee schedule	Effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate
Home health agency (provided by nurse)	Fee schedule	Effective 7/1/24: Lesser of maximum Medicare rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate, or maximum Medicaid rate in effect

Provider category	Basis of reimbursement	Upper limit
		6/30/24 plus 4.1%, converted to a 15-minute rate
Child development home or center	Fee schedule	Effective 7/1/22, provider's rate in effect 6/30/22 plus 4.25%, converted to a 15-minute rate. If no 6/30/22 rate: $3.76 per 15-minute unit
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: $10.43 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 11.727%
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/24: The fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30)
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 8/1/25: Provider's rate in effect 7/31/25 plus 0.9%, converted to a 15-minute rate. If no 7/31/25 rate: $3.97 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1)*"c,"* for the member's acuity tier, determined pursuant to 79.1(30)
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/24, $7,154.64 per year
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/24, $10.43 per 15-minute unit
29. In-home family therapy	Fee schedule	Effective 7/1/24, provider's rate in effect 6/30/24 plus 4.1%, converted to a 15-minute rate. If no 6/30/24 rate: $27.92 per 15-minute unit
30. Financial management services	Fee schedule	Effective 7/1/24, $77.51 per enrolled member per month
31. Independent support broker	Rate negotiated by member	Effective 7/1/24, $18.06 per hour
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2)
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2)
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 441—subparagraph 78.34(13)*"g"*(2)
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	$29.31 per day
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%

Provider category	Basis of reimbursement	Upper limit
Home- and community-based habilitation services:		
1. Case management	Fee schedule	Effective 7/1/22: Fee schedule in effect 6/30/22 plus 4.25%
2. Home-based habilitation	Fee schedule	Fee schedule in effect 7/1/24
3. Day habilitation	Fee schedule	Effective 7/1/24: $3.75 per 15-minute unit or $72.90 per day
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect 7/1/24
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed $3,692.34 per month
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed $3,692.34 per month
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/24. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,692.34 per month
Individual placement and support supported employment	Fee schedule	Fee schedule in effect 7/1/24. Total monthly cost for all supported employment services not to exceed $3,692.34 per month
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.5(11)*"q"*	Effective 7/1/22: The Medicaid LUPA fee schedule rate published on the department's website
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average
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 10/1/2021
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 1/1/2021
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)*"h"*	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare)
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule
Infant and toddler program providers	Fee schedule	Fee schedule

Provider category	Basis of reimbursement	Upper limit
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.4(249A)	Eightieth percentile of facility costs as calculated from annual cost reports
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 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 6/30/13 plus 1%
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.8(1) and 441—81.5(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—numbered paragraphs 81.5(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—numbered paragraphs 81.5(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 non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.5(4) and 81.5(14) and paragraph 81.5(16)*"f."* The direct care rate component limit under 441—subparagraphs 81.5(16)*"f"*(1) and *"f"*(2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—subparagraphs 81.5(16)*"f"*(1) and *"f"*(2) is 110% of the patient-day-weighted median
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.8(1) and 441—81.5(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—numbered paragraph 81.5(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—numbered paragraph 81.5(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	See 441—subrules 81.5(4) and 81.5(14) and paragraph 81.5(16)*"f."* The direct care rate component limit under 441—subparagraph 81.5(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—subparagraph 81.5(16)*"f"*(3) is 110% of the patient-day-weighted median

Provider category	Basis of reimbursement	Upper limit
	the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median	
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q"*	Fee schedule in effect 6/30/13 plus 1%
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18)
Pharmacist vaccine administration	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q"*	Fee schedule in effect 6/30/13 plus 1%
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/13 plus 1%
Anesthesia services	Fee schedule. See 79.1(7)*"d"*	Fee schedule in effect 7/1/17. See 79.1(7)*"d"*
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Qualified primary care services	See 79.1(7)*"c"*	Rate provided by 79.1(7)*"c"*
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8)
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/21: Non-state-owned facilities provider-specific fee schedule in effect
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.5(11)*"q"*	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21)
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) as amended to July 1, 2026, 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 an MCO, reimbursement from the MCO will be supplemented to achieve "1" or "2" above
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%

Provider category	Basis of reimbursement	Upper limit
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18

79.1(3) *Ambulatory surgical centers.*

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. 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 will be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)*"n."*

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" means a Medicaid patient 17 years or younger.

"Adult" means a Medicaid patient 18 years or older.

"Average daily rate" means 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" means the hospital's cost report with fiscal year end on or after January 1, 2019, and before January 1, 2020, except as noted in paragraph 79.1(5)*"x."* Cost reports will be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" means 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 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 will 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 will 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 will 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" means 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 will not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs will 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" means an add-on to the blended base amount, which will 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" means 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" means 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 will 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" means 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 for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" means cases that have an extraordinarily high cost as established in paragraph 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, appeals, and licensing pursuant to rule 481—51.27(135B).

"Diagnosis-related group" or *"DRG"* means a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" means 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 multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose and then case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs will be made from the graduate medical education and disproportionate share fund and will not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs will 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" means 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 a factor to maintain expenditures within the amount appropriated to the department for this purpose. 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 will 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" means a payment that will compensate for treatment of a disproportionate share of poor patients. The disproportionate share payment will be made directly from the graduate medical education and disproportionate share fund and will not be added to the reimbursement for claims.

"Disproportionate share percentage" means 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 subparagraph 79.1(5)*"y"*(7) for more information.)

A separate disproportionate share percentage will 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" means 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" means 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" means 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" means that a case, coded as a transfer to another hospital, will be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid base year cost report period. The claim set is updated in July of every third year and is modeled using recalibrated rates pursuant to paragraph 79.1(5)*"k."*

"GME/DSH fund implementation year" means 2022.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means 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" means 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 will 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" means 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" means cases that 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 paragraph 79.1(5)*"f."*

"Low-income utilization rate" means 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 will 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 claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2018, through December 31, 2019, and paid through March 31, 2020.

"Medicaid inpatient utilization rate" means 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 will 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" means a designated level II or level III neonatal unit.

"Net discharges" means total discharges minus transfers and short stay outliers.

"Rate table listing" means a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by a hospital before being multiplied by the appropriate DRG weight.

"Rebasing" means the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2021 and every three years thereafter.

"Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" means cases that 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 paragraph 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 paragraph 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 paragraph 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.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2021, 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 with Medicaid cost data less medical education from the Medicaid claim set using trimmed claims. Medicaid cost data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base year cost report will not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions pursuant to paragraph 79.1(5)*"b."* Weights are determined through the following calculations:

1. Determine the statewide geometric mean cost for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean cost for each DRG by multiplying the statewide geometric mean cost for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean costs for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average geometric mean cost for all DRGs.
4. Divide the statewide geometric mean cost for each DRG by the weighted average geometric mean cost 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 base year cost reporting period, 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.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index will be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation will use only claims and associated DRG weights 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 multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose:

1. The total calculated dollar expenditures based on hospitals' base year cost reports for capital costs and medical education costs, multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services, 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) 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, and direct medical education costs multiplied by an amount to maintain expenditures within the amount appropriated to the department for this purpose, and then subtracting payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services, 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 will 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 and then multiplied by a factor to maintain expenditures within the amount appropriated to the department for this purpose. 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 will 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) Reserved.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. One hundred percent of outlier costs will be paid to facilities at the time of claim reimbursement. Iowa Medicaid will perform retrospective outlier reviews.

(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 will 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 Iowa Medicaid 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 $75,000. 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 will 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 Iowa Medicaid must submit all requested supporting data to Iowa Medicaid 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 Iowa Medicaid 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 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 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 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 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 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 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 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.

(5) Inpatient readmissions within 30 days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay will be combined with the claim for the

original inpatient stay and payment will be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

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 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, psychiatric units, and acute psychiatric intensive care services. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided 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 a factor to maintain expenditures within the amount appropriated to the department for this purpose is applied.

(1) Per diem calculation. The base rate will 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) Per diem reimbursement. Hospitals will be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate will 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.

(3) Per diem recalculation. Hospital prospective reimbursement rates will be established based on the state's fiscal year.

(4) Acute psychiatric intensive care services. Services that meet the criteria at 441—subrule 78.3(8) will be reimbursed as follows:

1. Services provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* will be paid based on the hospital-specific per diem rate as calculated pursuant to subparagraph 79.1(5)*"i"*(1) plus a percentage increase as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.
2. Services not provided in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* will be paid based on the hospital-specific DRG payment rate as calculated pursuant to paragraph 79.1(5)*"b"* plus an add-on per diem rate as determined by the department for covered days billed with the appropriate psychiatric intensive care revenue code.

(5) Per diem billing. The current method for submitting billing and cost reports will 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 as amended to July 1, 2026, 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.

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors will 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 will be rebased and weights recalibrated in 2021 and every three years thereafter. Cost reports used in rebasing will 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 calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to Iowa Medicaid by May 31 of a rebasing implementation year, 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 will be updated as provided in subparagraphs 79.1(5)*"y"*(3), *"y"*(6), and *"y"*(9).

(4) Hospitals receiving reimbursement as critical access hospitals will not receive inflation of base payment amounts and will 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) Out-of-state hospitals do not qualify for disproportionate share payments.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)*"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that Iowa Medicaid reviews 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 Iowa Medicaid. Inpatient or outpatient services that require preadmission or preprocedure approval by Iowa Medicaid are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly to Iowa Medicaid 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 Iowa Medicaid 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 regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to Iowa Medicaid after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by Iowa Medicaid as described in paragraph 79.1(5)*"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 Iowa Medicaid at the department's address. 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 Iowa Medicaid to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by Iowa Medicaid, reimbursement will 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"* will be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by Iowa Medicaid to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid at the department's address, with documentation that the certification requirements are met. Iowa Medicaid 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 will be retroactive to the first day of the month during which Iowa Medicaid received the request for certification. No additional retroactive payment adjustment will 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 subparagraph 79.1(5)*"b"*(1) if the unit's program is licensed by the department as a substance abuse treatment program in accordance with Iowa Code chapter 125. 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 subparagraph 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 CFR Sections 412.25 and 412.27 as amended to July 1, 2026. 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 subparagraph 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 or the American Osteopathic Association. Iowa Medicaid will 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 department 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 CFR Sections 412.25 and 412.27 as amended to July 1, 2026.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if the physical rehabilitation hospital or unit receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 CFR Subpart P as amended to July 1, 2026, and the hospital is accredited by the Joint Commission or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, a health care access assessment inflation factor will be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.5(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals will be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor will not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36 has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor will terminate if the health care access assessment is terminated. If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department will:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

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, both as amended to July 1, 2026.

(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. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) 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. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and 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 Council on Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $0.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa 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 disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments will not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments will not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552, Hospital and Healthcare Complex Cost Report.

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. 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) as amended to July 1, 2026. 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 will be made to hospitals in Iowa 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. Iowa 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. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital 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 will be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education will 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 pursuant to paragraph 79.1(5)*"r"* for claims paid from the GME/DSH fund apportionment claim set 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.

(4) Qualifying for indirect medical education. Iowa 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. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital 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 will be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education will 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, pursuant to paragraph 79.1(5)*"r,"* for claims paid from the GME/DSH fund apportionment claim set 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.

(7) Qualifying for disproportionate share. 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 79.5(1)*"y"*(10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. 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 will 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) 2 ½ percent.

2. 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 will be 2½ percent.

3. 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 will 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.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage will 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.

5. 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 as amended to July 1, 2026, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. 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.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals do not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,959,868.59. 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 will be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share will 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, pursuant to paragraph 79.1(5)*"r,"* for claims paid from the GME/DSH fund apportionment claim set 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, pursuant to 79.1(5)*"r,"* 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 will 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.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234 as amended to July 1, 2026) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments, pursuant to paragraph 79.1(5)*"u"* or 79.1(5)*"v,"* cannot exceed the amount of the federal cap under Public Law 102-234 as amended to July 1, 2026.

(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 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. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions.

A hospital wishing to qualify for disproportionate share payments as a children's hospital must provide the following information to Iowa Medicaid 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. Reserved.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals, pursuant to paragraphs 79.1(5)*"a"* through *"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"* through *"z."* Amounts paid before adjustment that exceed reasonable costs will be recovered by the department.

(1) The base rate upon which the DRG payment is built will 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 Iowa Medicaid 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. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment will not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services, pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv) as amended to July 1, 2026, if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment will be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share will be funds generated from tax levy collections of the county or city in which the hospital is located and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year will apply.

(3) Amount of payment. The total amount of disproportionate share payments made, pursuant to paragraph 79.1(5)*"y,"* and the rural hospital disproportionate share payments will not exceed the amount of the state's allotment under Public Law 102-234 as amended to July 1, 2026. In addition, the total amount of all disproportionate share payments will not exceed the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department for the purpose

of calculating the hospital-specific disproportionate share limits under Public Law 103-666 as amended to July 1, 2026.

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 as amended to July 1, 2026. 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 CPT as amended to July 1, 2026. Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)*"a"* will be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting as opposed to the physician's office. For the purpose of this provision, a "facility" place of service (POS) is defined as any of the following (consistent with "POS" definitions under Medicare per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, amended to July 1, 2026):

(1) Telehealth (POS 02).
(2) Outpatient hospital-off campus (POS 19).
(3) Inpatient hospital (POS 21).
(4) Outpatient hospital-on campus (POS 22).
(5) Emergency room-hospital (POS 23).
(6) Ambulatory surgical center (POS 24).
(7) Military treatment center (POS 26).
(8) Skilled nursing facility (POS 31).
(9) Hospice-for inpatient care (POS 34).
(10) Ambulance-land (POS 41).
(11) Ambulance-air or water (POS 42).
(12) Inpatient psychiatric facility (POS 51).
(13) Psychiatric facility-partial hospitalization (POS 52).
(14) Community mental health center (POS 53).
(15) Psychiatric residential treatment center (POS 56).
(16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. Primary care services that are eligible for payment, pursuant to this rule, will be paid at the greater of:

(1) The otherwise applicable Iowa Medicaid rate;
(2) The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;
(3) The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. §1395w-4(d) as amended to July 1, 2026, were the conversion factor for 2009; or
(4) If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the CMS, pursuant to 42 CFR §447.405(a)(1), and in effect on June 30, 2014.

Notwithstanding the foregoing provisions of this paragraph (79.1(7)*"c"*), payment for the administration of vaccines provided under the Vaccines for Children Program will be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or
2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. §1395w-4(d) as amended to July 1, 2026, were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)*"c."* Anesthesia procedures listed in the fee schedule with a factor code of "F" are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of "A" are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. The Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount, which will be updated annually on January 1.

79.1(8) *Drugs.*

a. Except as provided in paragraphs 79.1(8)*"d"* through *"h,"* all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs will be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)*"b,"* plus the professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*;

2. The federal upper limit (FUL), defined as the upper limit for a multiple-source drug established in accordance with the methodology of CMA as described in 42 CFR 447.514(a)-(c) as amended to July 1, 2026, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"c"*;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*; or

4. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs will be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)*"b,"* plus the professional dispensing fee, determined pursuant to paragraph 79.1(8)*"c"*;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state-defined professional dispensing fee; or

3. Providers' usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies' average prices paid to acquire drug products. Average state AAC will be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys will be conducted at least once every six months or more often at the department's discretion. The average state AAC will be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department will be published on the department's website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span will be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee will be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey will be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose will be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the board of pharmacy's rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)*"a,"* reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) as amended to July 1, 2026, for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

2. The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to numbered paragraph 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4) as amended to July 1, 2026, will be according to paragraph 79.1(8)*"a"* because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(2) The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to numbered paragraph 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c";*

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR 447.508 as amended to July 1, 2026, will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(2) The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1) "2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.47(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.47(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)*"a"* through *"f."* The pharmacy encounter rate is the current "outpatient per visit rate (excluding Medicare)" approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, as amended to July 1, 2026, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)*"a"* through *"f,"* payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, will be pursuant to the physician payment policy under subrule 79.1(2).

j. Under this subrule, no payment will be made for sales tax.

k. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) Reserved.

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 will 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 that 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, that 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 will 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 subrule 79.1(1), will 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 that, or an individual who, advances money to a provider for accounts receivable that 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, that 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 will 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 will be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits will 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 will 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 will 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 will be charged to members for the following covered services:

a. The member shall pay a copayment of $1 for each covered prescription or refill of any covered drug.

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 rule 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 inpatient 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.

n. The member shall pay a $3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)*"k."* This $3 copayment will not apply if the visit to the emergency room results in a hospital admission.

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 will 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 will 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) will 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 brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS children's mental health waiver family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency under an HCBS intellectual disability waiver, brain injury waiver, or health and disability waiver.

a. Reporting requirements.

(1) Providers shall submit the completed certification form prescribed by the department. The provider shall email the report and required supplemental information to the email address specified on the form. The provider shall mail one signed copy of the certification page to Iowa Medicaid at the department's address, no later than the due date of the required electronic submissions.

(2) The provider shall submit a financial and statistical report coinciding with the provider's fiscal year.

(3) The provider shall submit the financial and statistical report on or before the last day of the third month following the end of the cost reporting period.

(4) A certified home health agency enrolled to deliver HCBS that is required to submit a Medicare cost report may request a 60-day extension for submitting the financial and statistical cost report. All other providers may request a 30-day extension for submitting the financial and statistical report. All requests must be submitted in writing to Iowa Medicaid by the financial and statistical report due date. No other extensions will be granted.

(5) If a provider terminates its participation in any HCBS program or service, the provider shall submit a final financial and statistical report on or before the sixtieth day following the date of termination for retrospective adjustment in accordance with subparagraph 79.1(15)*"f"*(1).

(6) Providers failing to submit a financial and statistical report that meets the requirements of this paragraph within the time frames set forth in subparagraph 79.1(15)*"a"*(3) or *"a"*(4), as applicable, will reduce payment to 76 percent of the current rate. The reduced rate will be paid for not longer than three months, after which time no further payments will be made.

(7) Providers shall submit a completed financial and statistical report in an electronic format that can be opened using the extension xls or xlsx. The provider shall submit supplemental documentation in a generally accepted business format.

(8) Along with its financial and statistical report, the provider shall include a working trial balance that corresponds to the data contained on the financial and statistical report. Financial and statistical reports submitted without a working trial balance will be considered incomplete.

(9) The provider's financial data within the financial and statistical report shall be based on the provider's financial records. When the records are not based on the accrual basis of accounting, the provider shall make adjustments necessary to convert the information to an accrual basis for reporting.

(10) Providers of multiple programs or services shall submit a cost allocation schedule. The schedule must identify an allocation method for each expense account, including the statistics used in the calculation.

(11) Providers shall not report costs to any waiver service that are costs of any other program or public or private funding sources, including but not limited to the Medicaid state plan; Medicare; other state, local or federal funded programs; and private funding sources. Providers shall not report costs of HCBS waiver services as a cost of any other public or private funding source.

(12) Iowa Medicaid or its designee may review or audit financial and statistical reports as filed to determine the actual cost of services in accordance with generally accepted accounting principles or Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1 as amended to July 1, 2026, subject to the exceptions and limitations in the department's administrative rules and financial and statistical report instructions.

(13) Failure to maintain records to support the financial and statistical report and make them available to the department or its designee upon request may result in adjustment, payment reduction, or sanction including but not limited to termination of the provider's HCBS certification.

(14) When adjustments made to prior reports indicate noncompliance with reporting instructions or the provider has a history of inadequate documentation to support the financial and statistical report, the department may require that an external accountant experienced with cost report preparation prepare the financial and statistical report or that a certified public accountant complete a review or examination of the financial and statistical report or cost allocation methodology.

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 the form specified by the department and have an approved service plan for the member.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Twenty percent identified cost limitation.

1. The following identified costs are not subject to the 20 percent limitation; however, the following costs are used to calculate the limitation:

- Wages, benefits, and payroll taxes.
- Direct care transportation expense—with and without member present.
- Direct care development, training, and supplies.
- Member-specific assistance.
- Member-specific equipment repair or purchase.

2. For each waiver service, the sum of reported costs not identified in numbered paragraph 79.1(15)*"b"*(3)"1" is limited to 20 percent of the identified costs in numbered paragraph 79.1(15)*"b"* (3)"1."

(4) Mileage reimbursement for business use of personal employee vehicles will be limited to the federal Internal Revenue Service's (IRS's) published mileage rate in effect during the cost reporting period.

(5) Compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function and do not exceed the maximum allowed compensation as described in numbered paragraphs 79.1(15)*"b"*(5)"5" and "6."

1. "Ownership" is defined as an interest of 5 percent or more. For this purpose, the following persons are considered immediate relatives: husband, wife, natural or adoptive parent, natural or adoptive child, natural or adoptive sibling, step-parent, step-child, step-sibling, parent-in-law, child-in-law, sibling-in-law, grandparent, or grandchild. Adequate time records shall be maintained.

2. "Compensation" means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest-issued W-2 and current compensation shall be required to be disclosed to Iowa Medicaid or its designee. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation will be considered unallowable for reimbursement. Providers shall report all compensation paid to related parties, including payroll taxes, on the financial and statistical report.

3. "Reasonableness" requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable providers, and depends upon the facts and circumstances of each case.

4. "Necessary" requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service and be pertinent to the operation and sound conduct of the institution.

5. The maximum allowed compensation for the executive director, corporate executive officer, or equivalent position, who is an owner or immediate relative, is equal to the intermediate care facility for persons with an intellectual disability (ICF/ID) maximum compensation for facilities with 60 beds or more pursuant to 441—subparagraph 82.4(11)*"e"*(4).

6. The maximum allowed compensation for any other owner or immediate relative is 60 percent of the amount allowed in numbered paragraph 79.1(15)*"b"*(5)"5."

7. The provider shall maintain records in the same manner for an owner or immediate relative compensated by the agency as are maintained for any employee of the agency, including but not limited to employment records, timekeeping, and payroll records.

8. The maximum allowed compensation for owners and immediate relatives shall be adjusted by the percentage of the average workweek devoted to business activity during the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one owner or immediate relative allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one agency.

9. Costs applicable to services, facilities, and supplies furnished to the provider by a person or organization related to the provider by common ownership or control are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

- "Related" means that the agency, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
- Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.
- Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.
- A provider may lease a facility from a related person or organization. In such case, the rent paid to the lessor by the provider is not allowable as a cost. The provider, however, would include in its cost the costs of ownership of the facility. This includes depreciation, interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility.
- An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence that the criteria in numbered paragraph 79.1(15)*"b"*(5)"10" have been met.

10. The agency must demonstrate the following with convincing evidence. Where all of the conditions below are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

- The supplying organization is a bona fide separate organization;
- A substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
- The services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and
- The charge to the agency is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies.

c. Prospective rates for new providers.

(1) "New providers" means providers who have not submitted an annual report including at least six months of actual, historical costs of operations for any service as listed in subrule 79.1(15).

(2) New providers will be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period.

(3) Projected costs of any new service, as listed in subrule 79.1(15), shall be submitted on the applicable form prescribed by the department.

(4) Prospective rates will be subject to retrospective adjustment as provided in paragraph 79.1(15)*"f."*

(5) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates will be determined as provided in paragraph 79.1(15)*"d."*

d. Prospective rates for established providers.

(1) "Established providers" means providers who have submitted an annual report including six months of actual, historical costs of operation.

(2) The prospective rate will be adjusted annually, effective the first day of the third month after the month during which the annual financial and statistical report is submitted to the department.

(3) The provider's prospective rate will be the lower of:

1. The provider's reasonable and proper actual cost-based rate as calculated by the provider's most recent financial and statistical report and adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end,

2. In the first year of reporting six months of actual, historical costs of operation, or a year in which the provider's base rate is recalculated, the base rate is equal to the amount calculated in numbered paragraph 79.1(15)*"d"*(3)"1,"

3. In a year in which the provider's base rate is not recalculated, the prior period base rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending as of the provider's fiscal year end, or

4. The upper rate limit pursuant to subrule 79.1(2).

(4) Recalculation of base rates (rebasing).

1. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency, the base rates will be recalculated based on the reasonable and proper actual costs of operation as calculated by the fiscal year 2022 financial and statistical report.

2. For providers of HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency; and 15-minute HCBS intellectual disability waiver supported community living services, the base rates will be recalculated based on the reasonable and proper costs of operation for the provider's fiscal year ending on or after January 1, 2024.

3. Subsequent to the recalculation of base rates in numbered paragraph 79.1(15)*"d"*(4)"2," a provider's base rate will be recalculated no less than every three years.

(5) Prospective rates will be subject to retrospective adjustment as provided in paragraph 79.1(15)*"f."*

e. Reserved.

f. Retrospective adjustments.

(1) For fee for service, retrospective adjustments will be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for 15-minute HCBS intellectual disability waiver supported community living services; HCBS brain injury waiver supported community living services; HCBS children's mental health waiver family and community support services; and interim medical monitoring and treatment services when provided by an HCBS-certified supported community living services agency under an HCBS intellectual disability waiver, brain injury waiver, and health and disability waiver, as reported on the applicable department form, subject to the upper rate limit allowed in subrule 79.1(2).

(2) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent for fee for service will be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) If a provider does not remit the amount of the overpayment identified in subparagraph 79.1(15)*"f"*(2) within 30 days after notice, the department will deduct the amount owed from future payments.

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 July 1, 2026, 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 January 1, 2024, means the hospital's cost report with fiscal year end on or after January 1, 2022, and before January 1, 2023. Cost reports will be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" means 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 will not be used in determining the statewide base APC rate.

"Cost outlier" means services provided during a single visit that have an extraordinarily high cost as established in paragraph 79.1(16)*"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" or *"CPT"* 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. For the purposes of this rule, "CPT" means the coding as amended to July 1, 2026.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" means 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 in determining the direct medical education rate.

"Direct medical education rate" means 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 factor used to limit aggregate expenditures to available funding and then divided by the sum of outpatient relative discounted APC weights.

"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.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid base year cost report. The claim set is updated every three years in July and is modeled using recalibrated weights pursuant to paragraph 79.1(5)*"k."*

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means 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 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.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2019, through December 31, 2020, and paid through March 31, 2020.

"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 as amended to July 1, 2026, and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 as amended to July 1, 2026.

"Outpatient visit" means those hospital-based outpatient services that 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.

"Rebasing" means the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" means 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 July 1, 2026, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services (CMS) to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to July 1, 2026, is eligible for combined billing status if the hospital has filed the approval notice with Iowa Medicaid. 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 will 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.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services will 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 will be reimbursed based on the APC to which the services provided are assigned. 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 and APCs will 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 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. ● Separately payable clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Separately payable nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy.	For services 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."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient 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 different bill type other than outpatient hospital (13x). ● 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.
E1	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.	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.

Indicator	Item, Code, or Service	OPPS Payment Status
E2	Items, codes, and services: ● 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.
J1	Hospital Part B services paid through a comprehensive APC	If covered by Iowa Medicaid, the service is paid under OPPS APC. All covered Part B services on the claim, except services with OPPS SI=F, G, H, L, and U; ambulance services; diagnostic and screening mammography; and all preventive services. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
J2	Hospital Part B services that may be paid through a comprehensive APC	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. ● In other circumstances, payment is made through a separate APC payment. If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	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.

Indicator	Item, Code, or Service	OPPS Payment Status
		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.
Q1	STV-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," or "V." ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	Paid under OPPS APC. ● Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. ● In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Q4	Conditionally packaged laboratory tests	Paid under OPPS APC or Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* ● Packaged APC payment if billed on the same claim as HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." ● In other circumstances, laboratory tests should have a status indicator of "A" and payment is made under the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."*
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.

Indicator	Item, Code, or Service	OPPS Payment Status
		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.
U	Brachytherapy sources	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.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)*"r."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, 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."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Reserved.

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.

(2) The cost-to-charge ratios are applied to each line-item charge reported on claims from the Medicaid claim set 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—paragraphs 78.31(1)*"g"* through *"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 and then divided by the hospital-specific sum of relative discounted APC weights in the Medicaid claim set.

(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—paragraphs 78.31(1)*"g"* through *"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 maintain expenditures within the amount appropriated to the department for this purpose and then divided by the sum of relative discounted APC weights in the Medicaid claim set.

(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"* will 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 will 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 will recover the difference.

(1) After any retrospective adjustment, the department will 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 will base these changes on the most recent utilization as submitted to the Iowa Medicaid and Medicare cost principles. Providers may be eligible for an "add-on" to the cost-to-charge ratio based on eligibility to participate in the annual Critical Access Hospital Cost Adjustment Factor Pool.

(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 as amended to July 1, 2026, 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, Hospitals and Healthcare Complex Cost Report);

2. Either the Critical Access Hospital Supplemental Cost Report or the 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 Iowa Medicaid at the department's address.

(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 will 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 will be rebased. Cost reports used in rebasing will 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 timelines 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 Iowa Medicaid 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 will be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund will 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 will be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs 79.1(16)*"k"*(1) and *"k"*(2).

(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) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)*"v."*

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by Iowa Medicaid are updated yearly and are available from the department.

(1) The hospital shall provide the Iowa Medicaid 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 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 regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid, pursuant to 441—Chapter 36, a health care access assessment inflation factor will be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.5(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals will be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating

hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor will not be implemented until federal financial participation to match money collected from the health care access assessment, pursuant to 441—Chapter 36, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor will terminate if the health care access assessment is terminated. If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department will:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;

2. Recompute Medicaid payments due based on the recalculated Medicaid rates;

3. Recoup any previous overpayments; and

4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

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 Iowa Medicaid to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement will 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. Reserved.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room will be made pursuant to a fee schedule. Payment for treatment of a Medicaid member in an emergency room will be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room will be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room will be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room will be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the APC methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 and 447.325, both as amended to July 1, 2026. 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. Reserved.

u. Iowa Medicaid review. The department 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.

v. Graduate medical education and disproportionate share fund. Payment will be made to 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. Iowa 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. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital 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 will be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education will 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 sum of updated OPPS relative discounted APC weights, pursuant to paragraph 79.1(16)*"j,"* for the GME/DSH fund apportionment claim set 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.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to Iowa Medicaid for prior approval before the modification is initiated or the equipment is purchased. Payment will not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable will be based on the least expensive item that meets the member's medical needs.

c. Payment for most items will be based on a fee schedule and will conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee will be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee will be the lowest charge determined by the department according to the Medicare reimbursement method described in Section

1834(a) of the Social Security Act (42 U.S.C. 1395m as amended to July 1, 2026), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee will be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price will be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price will be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment will be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment will not exceed 80 percent of the purchase allowance.

(8) No allowance will be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management (PCM) services reimbursement.* Pharmacist and PCM team members will 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 will 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 will 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
Preventive 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 will 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 will be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee will be established for translation and interpretation services, which will be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association as amended to July 1, 2026.

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in subrule 79.1(2), payments to rehabilitation agencies will be made as provided in the areawide fee schedule established for Medicare by the CMS as amended to July 1, 2026. The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association as amended to July 1, 2026. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims.* Subject to approval of a state plan amendment by CMS, payment for Medicare crossover claims will be made as follows.

a. Definitions. For purposes of this subrule:

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Medicaid-allowed amount" means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicare-allowed amount" means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare cost sharing" means the Medicare member's responsibility to pay for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

"Medicare crossover claim" means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare 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.

"Medicare deductible and coinsurance amounts" means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare provider reimbursement" means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Qualified Medicare beneficiary" or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)*"a."* Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

"Third-party payment" means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims will be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) and **79.1(24)** Reserved.

79.1(25) *Reimbursement for community mental health centers (CMHCs).* CMHCs may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department. Once a CMHC chooses the alternative reimbursement rate methodology, the CMHC may not change its elected reimbursement methodology to 100 percent of reasonable costs.

a. Cost-based reimbursement. For CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following:

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, Iowa Medicaid will 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, Iowa Medicaid will 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 Iowa Medicaid will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by Iowa Medicaid. Iowa Medicaid will 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) Iowa Medicaid will 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) Iowa Medicaid will 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 other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using a Financial and Statistical Report form. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552. The following requirements apply to all required cost reports:

(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 July 1, 2026.

(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 Iowa Medicaid at the department's address. A provider that is not hospital-based shall submit a Financial and Statistical Report form 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 a Financial and Statistical Report form and CMS Form 2552 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 Iowa Medicaid. 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, Iowa Medicaid will reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate will be paid for not longer than three months, after which time no further payments will be made.

79.1(26) *Home health services.*

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.*

a. Rate determination based on cost reports. Reimbursement will be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers will be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and Iowa Medicaid 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 will be subject to review or audit or both by Iowa Medicaid to determine the actual cost of services in accordance with generally accepted accounting principles, and Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, both as amended to July 1, 2026, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment will be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. Financial and statistical report submission and reporting requirements.

(1) The provider shall submit the complete Financial and Statistical Report form in an electronic format approved by the department to Iowa Medicaid within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to Iowa Medicaid. The extension request must be received by Iowa Medicaid before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to Iowa Medicaid in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to the email address on the form on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to Iowa Medicaid at the department's address no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27)*"b"* (4), the department will reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) will be effective the first day of the sixth month following the provider's fiscal year end and will remain in effect until the first day of the month after the delinquent report is received by Iowa Medicaid.

2. The reduced rate(s) will be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by Iowa Medicaid.

(6) 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 and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.2(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates will 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 program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program 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 private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items that had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify Iowa Medicaid when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27)*"b."*

(2) For facilities that terminate activity with Iowa Medicaid, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless of if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27)*"a"* shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, Iowa Medicaid will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) *Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.*

a. New providers. Providers who are newly enrolled will be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate will be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers will be provided only when such provider is enrolled with

Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan starts to pay.

"Eligible member" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"Health insurance premium payment (HIPP) program" or *"HIPP program"* has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use a Health Insurance Premium Payment (HIPP) Provider Invoice form.

(1) Payment will be made to eligible providers for a HIPP program-eligible member's coinsurance, copayment, and deductible when the HIPP program-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For daily supported community living services, residential-based supported community living services, full-day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) *"c"* provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the interRAI-Intellectual Disability (interRAI-ID) for individuals age 18 and over and the Child and Youth Mental Health Developmental Disability (ChYMH-DD) (for children and youth below age 18) assessment tools as amended to July 1, 2026. The completed interRAI assessment tool and scoring criteria are available on request from Iowa Medicaid.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the InterRAI-ID and ChYMH-DD scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. Acuity tier scores are derived from information contained in the following sections:

(1) Section A. Identification Information

(2) Section B. Intake and Initial History

(3) Section C. Community and Social Involvement

(4) Section D. Strengths, Relationships, and Supports

(5) Section E. Lifestyle

(6) Section F. Environmental Assessment

(7) Section G. Communication and Vision

(8) Section H. Cognition or Section I. Health Conditions

(9) Section N. Supports and Services

e. Tier redetermination. A member's acuity tier may be changed in the following circumstances:

(1) There is a change in the member's interRAI-ID or ChYMH-DD score as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).

(2) A completed Emergency Needs Assessment form indicates a change in the member's support needs. A member's case manager may request an emergency needs assessment when a significant change in the member's needs is identified. When a completed emergency needs assessment indicates significant

changes that are likely to continue, a full interRAI-ID or ChYMH-DD assessment shall be conducted and any change in the interRAI-ID or ChYMH-DD scores will be used to determine the member's acuity tier.
[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.2(249A) Sanctions.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

"Iowa Medicaid" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

"Person" means any individual human being or any company, firm, association, corporation, institution, or other legal entity. "Person" includes but is not limited to a provider and any affiliate of a provider.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual human being, firm, corporation, association, institution, or other legal entity that is providing or has been approved to provide medical assistance to a member 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 temporary cessation of payments due a person until the resolution of a matter in dispute between a person 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 person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) *Grounds for sanctions.* The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include but are not limited to the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections, appeals, and licensing's Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act that is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

t. Violation of a condition of probation, suspension of payments, or other sanction.

u. Loss, restriction, or lack of hospital privileges for cause.

v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

w. Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.

x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) *Sanctions.*

a. The department may impose any of the following sanctions on any person:

(1) A term of probation for participation in the medical assistance program.

(2) Termination from participation in the medical assistance program.

(3) Suspension from participation in the medical assistance program.

(4) Suspension of payments in whole or in part.

(5) Prior authorization of services.

(6) Review of claims prior to payment.

b. The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.

c. Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program will be retroactive to the date established by the CMS or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

(4) Upon notification from the U.S. Department of Justice, the department of justice, the department of inspections, appeals, and licensing, or a similar agency that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department will immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension will end upon notification that the person has responded to the demand in full.

79.2(4) *Imposition and extent of sanction.* The department will consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include but are not limited to:

a. Seriousness of the offense.

b. Extent of violations.

c. History of prior violations.

d. Prior imposition of sanctions.

e. Prior provision of provider education (technical assistance).

f. Provider willingness to obey program rules.

g. Whether a lesser sanction will be sufficient to remedy the problem.

h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) *Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR §1002.212 as amended to July 1, 2026, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members as provided in 42 CFR §1001.2005 and 1001.2006, both as amended to July 1, 2026, whenever the department initiates an exclusion under 42 CFR §1002.210 as amended to July 1, 2026.

79.2(7) *Notice of violation.*

a. Any order of sanction will be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction will also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, 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. If the provider fails to do so, the sanction will remain effective pending any subsequent appeal under 441—Chapter 2506. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 2506, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the department. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5)*"c."*

79.2(8) *Suspension or withholding of payments.* The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it will notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with Iowa Code section 249A.11 or 249A.47 are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance will the department reimburse a person for such civil monetary penalties or interest.

79.2(10) *Report and return of identified overpayment.*

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under Iowa Code section 249A.39 must be made in writing, addressed to Iowa Medicaid, and contain all of the following:

(1) Person's name.

(2) Person's tax identification number.

(3) How the error was discovered.

(4) The reason for the overpayment.

(5) Claim number(s), as appropriate.

(6) Date(s) of service.

(7) Member identification number(s).

(8) National provider identification (NPI) number.

(9) Description of the corrective action plan to ensure the error does not occur again, if applicable.

(10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.

(11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

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 shall 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. Unless otherwise indicated below, the provider may document the services in any format so long as the documentation adequately substantiates the medical necessity and that the services were rendered. The service record 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. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.

4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.35(5)*"c"* or *"d,"* 441—paragraph 77.42(12)*"e,"* or 441—numbered paragraph 78.9(10)*"a"*(1)"2," first bullet point.

5. Medication administration record (MAR). The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Mileage log. The name, date, purpose of the trip, and total miles for transportation provided as part of the service.

7. Narrative description of any incidents or illnesses or unusual or atypical occurrences that occur during service provision.

8. Any supplies dispensed as part of the service.

9. The first and last name and professional credentials, if any, of the person providing the service.

10. 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.

11. For 24-hour care, documentation for every shift of the services provided.

(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 health care provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim. Additionally, documentation requirements must meet the professional standards pertaining to the service provided. 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).

(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.
3. Other service documentation as applicable.

(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.
3. Other service documentation as applicable.

(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. Prenatal Risk Assessment form.
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.
7. Other service documentation as applicable.

(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. Prenatal Risk Assessment form.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Prenatal Risk Assessment form.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, or 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, or 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. Case Activity Report form.
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. Case Activity Report form.

(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. Resident Care Agreement form.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Case Activity Report form.

(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. Case Activity Report form.
6. Medication administration records.

(22) Hospice services:

1. Physician certifications for hospice care.
2. Election of Medicaid Hospice Benefit form.
3. Revocation of Medicaid Hospice Benefit form.
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.
4. Other service documentation as applicable.

(25) Behavioral health intervention:

1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.
4. Other service documentation as applicable.

(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, nurse practitioner, physician associate, or clinical nurse specialist 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. Notice of decision for service authorization.
2. Service notes or narratives.
3. Social history.
4. Comprehensive service plan.
5. Reassessment of member needs.
6. Incident reports in accordance with 441—subrule 24.4(5).
7. Other service documentation as applicable.

(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. HCBS Attendant Care Agreement and Attendant Care Service Record.
8. Other service documentation as applicable.

(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.
2. Waiver of informed consent.
3. Prior authorization documentation.
4. Service or office notes or narratives.

(39) Behavioral health services:
1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.
4. Other service documentation as applicable.

(40) Reserved.

(41) Services of public health agencies:
1. Service or office notes or narratives.
2. Immunization records.
3. Results of communicable disease testing.

(42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
1. Department-approved standardized neurobehavioral assessment tool.
2. Community-based neurobehavioral treatment order.
3. Treatment plan.
4. Clinical records documenting diagnosis and treatment history.
5. Progress or status notes.
6. Service notes or narratives.
7. Procedure, laboratory, or test orders and results.

8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.

9. Medication administration records.

10. Other service documentation as applicable.

(43) Child care medical services:

1. Plan of care.

2. Certification and recertification.

3. Service notes or narratives.

4. Physician orders or medical orders.

5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).

6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

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. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.

2. Individual stabilization plan.

3. Service notes or narratives (history and physical, therapy records, discharge summary).

4. Medication administration records (residential services).

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.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

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 Iowa Medicaid 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 have the right, upon proper identification, to audit or review the clinical and fiscal records 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 Iowa Medicaid will include a Documentation Checklist form, which is available on the department's website, 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.

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 79.4(3)*"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) For purposes of these rules, "good cause" has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(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 2506.

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 is 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 will be selected using accepted sample size estimation methods. The confidence level of the sample size calculation will 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 constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

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 Iowa Medicaid, the request should be addressed to Iowa Medicaid at the department's address.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to the department at its address.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph 79.4(5)*"a"* 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 will 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 2506. However, an appeal will not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) are not admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

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, both as amended to July 1, 2026, which prohibit discrimination on the basis of handicap in all federal Department of Health and Human Services funded programs.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

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 an Agreement Between Provider of Medical and Health Services and the Iowa Department of Health and Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION:

Dental providers are required to complete an 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.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.7(249A) Medicaid advisory council.

79.7(1) *Officers.*

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by the department. The initial ballot will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with department staff and the director, taking into consideration the following:

1. Work plans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) *Membership.* The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every fiscal year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department.

(1) The length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2)*"a"*(3).

b. Council membership of public representatives shall consist of five representatives, of whom one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. Reserved.

d. Council membership shall also consist of state agency and medical school partners, including representatives from Des Moines University Medicine and Health Sciences and the University of Iowa Carver College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 4A.13. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) *Responsibilities, duties and meetings.* The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department.

a. Recommendations. Recommendations made by the council shall be advisory and not binding upon the department or the professional and business entities represented. The director will consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department.

(1) Council meetings.

1. The council will meet quarterly at a minimum.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and

human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) *Procedures.*

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) *Expenses, staff support, and technical assistance.* Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department. The department will arrange for a meeting place, related services, and accommodations. The department will provide staff support and independent technical assistance to the council.

a. The department will provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department will present the annual budget for the medical assistance program for review and comment.

c. The department will permit staff members to appear before the council to review and discuss specific information and problems.

d. The department will maintain a current list of members on the council.

e. The department will be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.8(249A) Beneficiary advisory council. Pursuant to 42 CFR 431.12(e), Iowa Medicaid will form and support a beneficiary advisory council. The council will be governed by bylaws, which are available on the department's website.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.9(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through an MCO. For services provided through an MCO, the prior authorization request is submitted, reviewed, and authorized by the MCO.

79.9(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures, other than prescription drugs, by mail or by facsimile transmission (fax) using an Outpatient Prior Authorization Request form, 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 must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to Iowa Medicaid. 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 a Prior Authorization Attachment Control form as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on that form the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.9(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.9(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 of prescription drugs 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.

c. Decisions regarding approval or denial for items or procedures other than prescription drugs will be made according to the time frames set forth in 42 CFR 438.210(d) as amended to July 1, 2026.

79.9(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.9(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.9(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 subrule 79.9(1).

79.9(7) Requests for prior approval of services will be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval will be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive covered procedures that would be as effective.

(5) The advice of an appropriate professional consultant.

b. When Iowa Medicaid has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.9(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of policies is available in the provider manual distributed and updated to all participating providers.

79.9(9) Iowa Medicaid will issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. Iowa Medicaid will mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.9(10) If a request for prior approval is denied by Iowa Medicaid, 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 2506.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.10(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.10(1) Medicare definitions and policies apply to services provided unless specifically defined differently.

79.10(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 that 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.

79.10(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.10(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.

79.10(5) 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.

79.10(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.10(7) Incorrect payment.

a. Except as provided in paragraph 79.10(7)*"b,"* medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.10(7)*"a,"* medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.10(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.11(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by Iowa Medicaid as required in rule 441—78.3(249A).

79.11(1) The patient's admitting physician, the physician's designee, or the hospital will contact Iowa Medicaid to request approval of Medicaid coverage for the hospitalization according to instructions issued to providers by Iowa Medicaid and instructions in the Medicaid provider manual.

79.11(2) Medicaid payment will not be made to the hospital if Iowa Medicaid denies the procedure requested in the preadmission review.

79.11(3) Iowa Medicaid will 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 Iowa Medicaid within 60 days of the date of the denial letter.

79.11(4) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid according to 441—Chapter 2506.

79.11(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 73.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.12(249A) Requests for preprocedure surgical review. Iowa Medicaid 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).

79.12(1) The physician must request approval from Iowa Medicaid 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 Iowa Medicaid.

79.12(2) Iowa Medicaid will issue the physician a validation number for each request and advise whether payment for the procedure will be approved or denied.

79.12(3) Iowa Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, e.g., hospital or ambulatory surgical center, if Iowa Medicaid does not give approval.

79.12(4) Iowa Medicaid will 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 Iowa Medicaid within 60 days of the date of the denial letter.

79.12(5) The aggrieved party may appeal a denial of a request for reconsideration by Iowa Medicaid in accordance with 441—Chapter 2506.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.13(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:

79.13(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 an HMO at the time of enrollment of the person with the organization shall provide written information to each adult that 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.

79.13(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.13(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.

79.13(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.13(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 that allows for an objection on the basis of conscience for any provider or organization that as a matter of conscience cannot implement an advance directive.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.14(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) and Public Law 100-578, both as amended to July 1, 2026, and implementing federal regulations published at 42 CFR Part 493 as amended to July 1, 2026. Medicaid payment will 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.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.15(249A) Provider enrollment.

79.15(1) Application request. Iowa Medicaid providers, including those enrolled with an MCO, shall begin the enrollment process by completing the appropriate application on the department's website. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit a Medicaid HCBS Provider Application form at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit an Iowa Medicaid Ordering/Referring Provider Enrollment Application form.

c. All other providers shall submit an Iowa Medicaid Provider Enrollment Application form.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.11(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in rule 441—82.3(249A).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using a Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application form.

g. Health insurance premium payment (HIPP) providers shall enroll using a Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application form.

79.15(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to Iowa Medicaid at the department's address.

a. 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.

b. With the application form, an assertive community treatment program shall submit an Assertive Community Services (ACS) Provider Agreement Addendum and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. Reserved.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C) as amended to July 1, 2026.

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under Iowa Code section 249A.48.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.15(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR §455.460 as amended to July 1, 2026.

79.15(3) Program integrity information requirements.

a. All providers, including but not limited to MCOs and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455 as amended to July 1, 2026. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.15(3)*"a"*(1), *"a"*(2), *"a"*(3), *"a"*(4), or *"a"*(5).

b. Iowa Medicaid may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 2506, but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. Iowa Medicaid will deny enrollment to or immediately disenroll any person that Iowa Medicaid, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and will deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)*"c."* Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term "direct or indirect affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control or influence any other; or

(5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.15(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the "limited," "moderate," or "high" categorical risk screening procedures and requirements in accordance with 42 CFR §455.450 as amended to July 1, 2026.

a. For the types of providers that are recognized as a provider under the Medicare program, Iowa Medicaid will use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518 as amended to July 1, 2026.

b. Provider types not assigned a screening level by the Medicare program will be subject to the procedures of the "limited" risk screening level pursuant to 42 CFR §455.450 as amended to July 1, 2026.

c. Adjustment of risk level. Iowa Medicaid will adjust the categorical risk screening procedures and requirements from "limited" or "moderate" to "high" when any of the following occurs:

(1) Iowa Medicaid imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state's Medicaid program; or

(2) Iowa Medicaid or CMS in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.15(5) Notification. A provider will be notified of the decision on the provider's application within 30 calendar days of receipt by Iowa Medicaid of a complete and correct application with all required documents, including but not limited to, if applicable, any application fees or screening results.

79.15(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 2506.

79.15(7) Effective date of approval. An application 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 with all required documents by Iowa Medicaid.

79.15(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.15(9) No payment will be made to a provider for care or services provided prior to the effective date of Iowa Medicaid's approval of an application.

79.15(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided will be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.15(11) An amendment to an application shall be submitted to Iowa Medicaid and will be approved or denied within 30 calendar days. Approval of an amendment will 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 Iowa Medicaid. Denial of an amendment may be appealed under 441—Chapter 2506.

79.15(12) Inactivity and provider status. A provider that has not submitted a claim within the last 12 months will be deactivated from participation in Iowa Medicaid. A deactivated provider may request reactivation by contacting Iowa Medicaid and meeting all applicable re-enrollment requirements pursuant to this rule. A provider that remains inactive and does not submit any claims for 24 consecutive months following deactivation will be terminated as a provider without further notification.

79.15(13) Report of changes. The provider shall inform Iowa Medicaid of all pertinent changes to enrollment information within 35 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, telephone number, or any information required to be disclosed by subrule 79.15(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, Iowa Medicaid may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 2506. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to Iowa Medicaid in a timely manner, the fine or repayment shall be the

responsibility of the individual provider to the extent that the fine or repayment 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 or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 2506.

79.15(14) Provider termination or denial of enrollment. Iowa Medicaid must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416 as amended to July 1, 2026.

79.15(15) Temporary moratoria. Iowa Medicaid must impose any temporary moratorium pursuant to Iowa Code section 249A.48.

79.15(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.15(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.15(3) or any failure to report a change required by subrule 79.15(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed Iowa Medicaid while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26; **ARC 0539D**, IAB 9/2/26, effective 8/10/26]

441—79.16(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.

79.16(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, that provide detailed information about:

(1) The False Claims Act established under 31 U.S.C. Sections 3729 through 3733 as amended to July 1, 2026;

(2) Administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38 as amended to July 1, 2026;

(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 79.16(1)*"a"*(1) through *"a"*(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 42 U.S.C. Section 1320a-7b(f) as amended to July 1, 2026; 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 79.16(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.

79.16(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 Iowa Medicaid 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 79.16(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 Iowa Medicaid at the department's address; or

(2) Faxing the information to 515.725.1354.

79.16(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, as amended to July 1, 2026.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

441—79.17(249A) Requirements for prescribing controlled substances.

79.17(1) *Review of Iowa prescription monitoring program database.* A prescribing practitioner, as defined in Iowa Code section 124.550, or the prescribing practitioner's designated agent, shall review patient information in the Iowa prescription monitoring program (PMP) database prior to issuing a prescription for a controlled substance as defined in 42 U.S.C. 1396w–3a, inclusive of Schedules II, III and IV as amended to July 1, 2026, unless the patient is receiving inpatient hospice care or long-term residential facility care. Review shall be conducted in accordance with all requirements under the prescribing practitioner's specific professional licensing authority.

79.17(2) *Documentation.* The prescribing practitioner shall include documentation in the patient file to demonstrate compliance with subrule 79.17(1). Subject to the requirements under Iowa Code chapter 124, subchapter VI, if the prescribing practitioner is not able to conduct a review of the PMP database despite a good-faith effort, the prescribing practitioner must document in the patient file such good-faith effort, including the reasons why the prescribing practitioner was not able to conduct the review. The prescribing practitioner shall submit such documentation to Iowa Medicaid upon request.

This rule is intended to implement Iowa Code chapters 124 and 249A.

[**ARC 0316D**, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code chapter 249A.

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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.

7 July 1, 2009, effective date of amendments to 79.1(1)"d," 79.1(2), and 79.1(24)"a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

8 See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7)*"b"* (ARC 9959B, IAB 1/11/12).

[9] July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.

[10] March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020.

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 80]

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

441—80.1(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to Iowa Medicaid on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after the end of the calendar month in which the services are provided. Following audit of the claim, Iowa Medicaid will make payment to the provider of care. The provider manual, Chapter IV, Billing Iowa Medicaid, found on the department's website and as amended to July 1, 2026, will detail the specific manner and frequency in which claims are to be submitted.

80.1(1) Electronic submission. Providers are required to submit claims electronically whenever possible.

80.1(2) For fee-for-service members, providers billing claims for Medicare beneficiaries that do not cross over electronically to Iowa Medicaid must submit the following electronically, in accordance with the All Providers manual, Chapter IV, Billing Iowa Medicaid, located on the department's website and as amended to July 1, 2026:

a. Form UB-04.

b. Form CMS-1500. The Explanation of Medicare Benefits (EOMB) is only required when requested by Iowa Medicaid.

[**ARC 0317D**, IAB 5/27/26, effective 7/1/26]

441—80.2(249A) Payment from other sources. This rule applies to claims for the department, managed care organizations, and the Public Health Associate Program (PHAP).

80.2(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source will be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.2(2) *Third-party liability.*

a. When a third-party liability for medical expenses exists, this resource will be utilized for payment of a claim before the Medicaid program makes payment unless:

(1) The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This "pay and chase" provision applies to claims for:

1. Preventive pediatric services, and
2. All services provided to a person for whom there is court-ordered medical support.

(2) Otherwise authorized by the department.

b. All claims must be clean claims. A clean claim is defined as a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim.

80.2(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. No later than 60 days after receiving any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service, respond to such inquiry, pursuant to 42 U.S.C. Section 1396a(25)(I)(iii) as amended to July 1, 2026.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point of sale that is the basis of the claim, or, in the case of a responsible third party (other than the original Medicare fee-for-service program under Parts A and B of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a Medicare Advantage plan offered by a Medicare Advantage organization under Part C of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026, a reasonable cost of reimbursement

plan under 42 U.S.C. Section 1395mm as amended to July 1, 2026, a health care prepayment plan under 42 U.S.C. Section 1395l as amended to July 1, 2026, or a prescription drug plan (PDP) offered by a PDP sponsor under Part D of 42 U.S.C. Chapter 7, Subchapter XVIII as amended to July 1, 2026), a failure to obtain a prior authorization for the item or service for which the claim is being submitted, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

d. Agree not to deny any claim submitted by the state solely because of lack of prior authorization.

[**ARC 0317D**, IAB 5/27/26, effective 7/1/26]

441—80.3(249A) Time limit for submission of claims and claim adjustments.

80.3(1) *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by Iowa Medicaid exceeds 365 days. The department will consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.3(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by Iowa Medicaid within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.3(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

[**ARC 0317D**, IAB 5/27/26, effective 7/1/26]

441—80.4(249A) Authorization process.

80.4(1) *Identification cards.* The department will issue a medical assistance eligibility card to members for use in securing medical and health services available under the program except as provided in 441—Chapter 76.

a. The department will issue the medical assistance eligibility card:

(1) When the member's eligibility is initially determined.

(2) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The medical assistance eligibility card is valid only for months in which the member has established eligibility as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.4(2) Reserved.

[**ARC 0317D**, IAB 5/27/26, effective 7/1/26]

441—80.5(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below.

80.5(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with 441—Chapter 75.

80.5(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.5(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

a. Related to the cost of processing the billing.

b. Not related on a percentage or other basis to the amount that is billed or collected.

c. Not dependent upon the collection of the payment.

[**ARC 0317D**, IAB 5/27/26, effective 7/1/26]

441—80.6(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406 as amended to July 1, 2026), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

80.6(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. A data use agreement shall prescribe the specific detail elements required, any privacy protections, the manner in which information shall be provided to the department or its designee, and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department or its designee to match covered persons and identify third-party payors for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

80.6(2) *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended to July 1, 2026; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164 as amended to July 1, 2026.

[**ARC 0317D**, IAB 5/27/26, effective 7/1/26]

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CHAPTER 81
NURSING FACILITIES
[Prior to 7/1/83 Social Services[770] Ch 81]
[Prior to 2/11/87, Human Services[498]]

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

441—81.1(249A) Definitions.

"Abuse" means any of the following that occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury that is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or section 726.2 or 728.12(1), or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident, which means the act or process of taking unfair advantage of a resident or the resident's physical or financial resources for one's own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident's life or health.

"Advance directive" means the same as defined in 42 CFR 489.100 (as amended to August 1, 2024).

"Allowable costs" means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in rules.

"Beginning eligibility date" means date of an individual's admission to the facility or date of eligibility for medical assistance, whichever is the later date.

"Case mix" means a measure of the intensity of care and services used by similar residents in a facility.

"Case-mix index" means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

"Civil penalty" means a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

"Clinical experience" means application or learned skills for direct resident care in a nursing facility.

"Clock hour" means 60 minutes.

"CMS" means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

"Complete replacement" means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

"Cost normalization" refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility's per diem direct care component costs by the facility cost report period case-mix index.

"Denial of critical care" is a pattern of care in which the resident's basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident's serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

"Direct care component" means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.

"Discharged resident" means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility.

"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR 483.5 (as amended to August 1, 2024) to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

"Facility-based nurse aide training program" means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

"Facility cost report period case-mix index" is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

"Facilitywide average case-mix index" is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

"Informed consent" means a resident's agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

"Laboratory experience" means practicing care-giving skills prior to contact in the clinical setting.

"Level I review" means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 (as amended to August 1, 2024).

"Level II review" means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

"Major renovations" means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds $750,000. The $750,000 threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility's financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the $750,000 threshold.

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

"Medicaid average case-mix index" is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

"Minimum data set" or *"MDS"* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility's case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.5(16)*"b,"* for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.5(16)*"c"* and *"e,"* the excess payment allowance pursuant to paragraph 81.5(16)*"d,"* and the limits on reimbursement components pursuant to paragraph 81.5(16)*"f."* MDS is described in subrule 81.12(9).

"Minimum food, shelter, clothing, supervision, physical or mental health care, or other care" means that food, shelter, clothing, supervision, physical or mental health care, or other care that, if not provided, would constitute denial of critical care.

"Mistreatment" means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact that is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

"New construction" means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

"Non-direct care component" means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report. Support care costs will include costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

"Non-facility-based nurse aide training program" means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

"Non-state government owned nursing facility" or *"NSGO nursing facility"* is a nursing facility owned by a governmental entity that is not the state.

"Nurse aide" means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

"Nurse aide registry" means the nurse aide registry within the department of inspections appeals, and licensing.

"Nurse aide training and competency evaluation programs" or *"NATCEP"* means educational programs approved by the department of inspections, appeals, and licensing for nurse aide training as designated in subrule 81.13(3).

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"PASRR" means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C (as amended to August 1, 2024).

"Patient-day-weighted median cost" means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

"Physical abuse" means any nonaccidental physical injury, or injury that is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

"Physical injury" means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue that results in the death of the person who has sustained the damage.

"Poor performing facility" or *"PPF"* is a facility designated by the department of inspections, appeals, and licensing as a PPF based on surveys conducted by the department of inspections, appeals, and licensing pursuant to subrule 81.12(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.12(19)*"o."*

"Primary instructor" means a registered nurse responsible for teaching a state-approved nurse aide training course.

"Program coordinator" means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

"Rate determination letter" means the letter that is distributed quarterly by the department to each nursing facility notifying the facility of the facility's Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 (as amended to August 1, 2024).

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Skills performance record" means a record of major duties and skills taught that consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

"Special population nursing facility" refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 30 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with mental illness.
4. One hundred percent of the residents require care from a facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with medical complexity.

"Surgical or other invasive procedure" means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association, as amended to August 1, 2024, and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. "Surgical or other invasive procedure" does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

"Terminated from the Medicare or Medicaid program" means a facility has lost the final appeal to which it is entitled.

"Testing entity" means a person, agency, institution, or facility approved by the department of inspections, appeals, and licensing to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)*"a,"* and 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.2(249A) Initial approval for nursing facility care.

81.2(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.2(1)*"b,"* will be made by the department within two working days of receipt of medical information. The department determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level II PASRR review pursuant to subrule 81.2(3), the level of care determination will be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

c. Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 2506.

81.2(2) *Preadmission review.* The department's contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person's care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department's contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person's attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person's physical condition, and the person is not a danger to self or others. If the person's nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person's illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person's caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and

2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and

3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and

4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

b. Outcome of Level II review. The Level II review shall determine:

(1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

(2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.12(14)*"b,"* using the procedures set forth in 42 CFR 483.134 (as amended to August 1, 2024); and

(3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.12(14)*"c,"* using the procedures set forth in 42 CFR 483.136 (as amended to August 1, 2024).

c. The department or its designee will review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

(1) Only if a Level I review was completed prior to admission;

(2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.2(3)*"a"* has been approved, and it is determined by the department that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person's treatment needs related to a mental illness or intellectual disability will be or are being met.

e. Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 2506.

f. A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident's lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 2506, no hearing will be granted unless the nursing facility submits a document providing such resident's consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident's knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility's bringing the state fair hearing on the resident's behalf.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)*"a,"* and 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—81.3(249A) Arrangements with residents.

81.3(1) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.3(2) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See paragraph 81.12(5)*"c."*) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.5(249A) if the service cannot be obtained free of charge. The department will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification will be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department will turn the funds over to the estate.

81.3(3) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)*"a,"* and 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.4(249A) Discharge and transfer. (See paragraph 81.12(6)*"c."*)

81.4(1) *Notice.* When a Medicaid member requests transfer or discharge, or another person requests this for the member, the administrator shall promptly notify the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

81.4(2) *Case activity report.* A Case Activity Report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.4(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.4(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

h. Resident care review team assessment.

81.4(5) *Unused client participation.* When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)*"a,"* and 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.5(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report to the department. All Medicare-certified hospital-based nursing facilities must submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.5(1) *Failure to maintain records.* Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility, may result in the penalties specified in subrule 81.14(1).

81.5(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities that are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of "direct patient care costs" and "support care costs." Costs associated with food and dietary wages shall be included in the "support care costs" subcategory.

81.5(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the department not later than the last day of the fifth calendar month after the close of the provider's reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the facility's established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the department to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.5(3)*"e."*

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.5(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate will be effective the first day of the sixth month following the provider's fiscal year end and will remain in effect until the first day of the month after the delinquent report is received by the department.

(2) The reduced rate will be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the department.

f. When a nursing facility continues to include in the total costs an item or items that had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the department can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the department 60 days prior to the first date of the change.

81.5(4) *Payment at new rate.*

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates will be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below will be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, will be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed $94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.5(16). In no case will the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed $94, times an inflation factor pursuant to subrule 81.5(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case will the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.5(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

b. The Medicaid payment rate for special population nursing facilities will be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities will be updated annually without a quarterly adjustment.

81.5(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.5(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

81.5(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.5(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.5(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.5(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinence, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services that are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.5(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following:

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal costs shall be prorated. Amounts that appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility that supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in

Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings that provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation includes all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the department. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the department with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report will be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.5(3)*"e."*

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is $3,296 per month plus $35.16 per month per licensed bed capacity for each bed over 60, not to exceed $4,884 per month. An administrator

is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.5(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.5(11)*"h"*(4) through 81.5(11)*"h"*(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. For financial and statistical reports received after March 18, 2020, the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (2023 edition).

(2) Limitation—full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.5(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) Necessary requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and that are held separate and not commingled with other funds.

(3) Proper requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those that commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. For financial and statistical reports received after March 18, 2020, the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.5(11)*"l,"* the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.5(11)*"j"* plus the landlord's other expenses, plus a reasonable rate of return; or

2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.5(11)*"l,"* the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.5(11)*"j"* plus the landlord's other expenses; or

2. Actual rent payments.

n. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and

other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. However, facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

o. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36 shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.5(21)*"a."*

p. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5)*"d."* The department will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

q. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the department will adjust each provider's reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments will be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

r. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

s. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

t. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

u. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.5(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner

will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership that is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership that is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property is allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act (as amended to August 1, 2024) regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation that verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.5(13) *Amended reports.* The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.5(14) *Payment to new facility.* The payment to a new facility will be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.5(16)*"c."* After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component will be adjusted by the facility's average Medicaid case-mix index pursuant to subrule 81.5(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility's first fiscal year, rates will be established in accordance with subrule 81.5(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year.

81.5(15) *Payment to new owner.* An existing facility with a new owner will continue to be reimbursed using the previous owner's per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility's fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year. The facility shall notify the department of the date the facility's fiscal year will end.

81.5(16) *Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.* This subrule provides for the establishment of the modified price-based reimbursement rate.

a. Calculation of per diem cost. For purposes of calculating the non-state government owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs will be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility's per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost will be determined by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001; July 1, 2003; July 1, 2004; July 1, 2005; and every second year thereafter, total reported allowable costs will be adjusted using the inflation factor specified in subrule 81.5(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state government owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days as determined in subrule 81.5(7) or 85 percent of the licensed capacity of the facility, whichever is greater. For the reimbursement period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days as determined in subrule 81.5(7)) or 70 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses will be inpatient days as determined in subrule 81.5(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.5(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.5(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median will be established for both the non-state government owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state government owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state government owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians will be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.5(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting will be recalculated. The non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians will be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.5(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, will be inflated to July 1, 2004, using the inflation factor specified in subrule 81.5(18).

d. Excess payment allowance.

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area as defined by CMS, not including Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.5(16)*"b"* times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)*"a."* In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area as defined by CMS (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.5(16)*"b"* times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

The wage index factor will be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by CMS each July. The geographic wage index adjustment will not exceed $8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater

than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)*"a."* In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.5(16)*"b"* times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)*"a."* In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph *"d,"* not to exceed the rate component limits determined by the methodology in paragraph *"f."*

(1) For non-state government owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.5(19), plus the allowed excess payment allowance as determined by the methodology in paragraph *"d."*

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph *"d"* and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph *"h."*

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities will be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.5(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs *"d"* and *"e,"* in no instance will a rate component exceed the rate component limit defined as follows:

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph *"d"* times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph *"h."*

g. Pay-for-performance program. Additional reimbursement based on the nursing facility pay-for-performance program is available for non-state government owned nursing facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility's achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the "payment period") for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types will not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, "direct care staff" is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. "Direct care staff" does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The department will annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8).

The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	Payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	Payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	Payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	Payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	Payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	Payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	Payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts.	Payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	Payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification
Subcategory: Resident Satisfaction			
Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be	Survey completed between October 1 and March 31 of the payment period	5 points	Nursing Facility Opinion Survey Transmittal, submitted by independent

Standard	Measurement Period	Value	Source
developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility. To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.			entity that compiled results
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations. If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to August 1, 2024, the facility is deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIAL list of facilities meeting the standard
Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points. A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIAL list of facilities meeting the standard
Subcategory: Staffing			
Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities. Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours will be normalized to remove variations in staff hours associated with different levels of resident case mix.	Facility fiscal year ending on or before December 31 of the payment period	5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation 10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation	Financial and Statistical Report, as analyzed by the department. The facility cost report period case-mix index shall be used to normalize nursing hours.
Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.	Facility fiscal year ending on or before December 31 of the payment period	5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%	Financial and Statistical Report, as analyzed by the department

Standard	Measurement Period	Value	Source
		10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%	
Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.	Calendar year ending December 31 of the payment period	5 points	Self-certification
Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility. To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	Survey completed between October 1 and March 31 of the payment period	5 points	Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the mean percentage of occurrences	Department report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	Department report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	Department report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures:	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of	Department report based on MDS data as reported by CMS

Standard	Measurement Period	Value	Source
The facility received at least 9 points from a combination of the measures listed in this subcategory.		nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIAL list of facilities meeting the standard
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Financial and Statistical Report, as analyzed by the department

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Financial and Statistical Report, as analyzed by the department
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Financial and Statistical Report, as analyzed by the department

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data will be drawn from a report submitted by the facility to the department. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to the department on the Nursing Facility Opinion Survey Transmittal. The department will request required source reports from the long-term care ombudsman and the department of inspections, appeals, and licensing.

(10) Calculation of potential add-on payment. The number of points awarded will be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

Score	Amount of Add-on Payment
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department will request the department of inspections, appeals, and licensing to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections, appeals, and licensing, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program will be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the department will:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.5(16)*"g"*; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete the Nursing Facility Medicaid Enhanced Payment Report to report the use of any additional payments received for the nursing facility pay-for-performance program. The report is due to the department each year by May 1. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department will publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the CMS and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph *"f."*

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph *"f."* The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or

2. Development of home- and community-based waiver program services; or

3. Improving infection control by replacing or enhancing an HVAC system, as defined in Iowa Code section 105.2.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent. Medicaid patient day utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total patient days as reported on the facility's most current financial and statistical report. Medicaid hospice patient days will be counted toward the total nursing facility Medicaid patient days.

2. The facility meets the accountability measure criteria set forth in paragraph *"g,"* subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.

2. Services shall be provided on the direct site of the facility but not as a nursing facility service.

3. Services shall meet all federal and state requirements for Medicaid reimbursement.

4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the department. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule that clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions; and
- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days will be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.

2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.

3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).

4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days will be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days will be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government-owned facilities will be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. Estimated amounts and actual amounts will be reconciled as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on will be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on will be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph *"f."*

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the department will recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation will be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days will be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned

nursing facilities will be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The recalculated capital cost per diem instant relief add-on will be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph *"f."* The facility's quarterly rates for the relevant period will be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid will be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit will be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or

2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date will be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval will be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the department is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or

2. The facility does not make reasonable progress on any plans required for initial qualification; or

3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership will continue under the new owner. Future reimbursement rates will be determined pursuant to subrules 81.5(15) and 81.5(16).

i. Quality incentive payment program (QIPP). The QIPP add-on rate will be made to a qualified non-state government-owned nursing facility (NSGO nursing facility) to promote, maintain, and improve resident quality of care and health outcomes.

(1) An NSGO nursing facility qualifies for participation in the QIPP if all the following conditions are met:

1. The NSGO nursing facility has executed a participation agreement with the department.

2. The NSGO nursing facility has provided proof that the entity holds the NSGO nursing facility's license and has complete operational responsibility for the NSGO nursing facility.

3. The NSGO nursing facility has filed a certification of eligibility application for the QIPP add-on rate program with the department and has received approval from the department for participation in the program.

4. The NSGO nursing facility is in compliance with all care criteria requirements.

5. The non-state government entity (NSGE) has executed a nursing facility provider contract with an NSGO nursing facility.

6. The NSGE has provided and identified the source of state share dollars for the intergovernmental transfer (IGT).

7. The NSGO nursing facility has provided proof of ownership, if applicable, as the licensed operator of the NSGO nursing facility.

8. The NSGO nursing facility has provided to the department an executed management agreement between the NSGE and the NSGO nursing facility manager if applicable.

(2) If at any time a provider is determined not eligible due to not meeting survey standards, the provider will be disqualified for the remainder of the year.

(3) An NSGO nursing facility will qualify for participation in the QIPP if all the following quality measures are met:

Quality Measures	Metrics	Tracking/Scoring	Data Resource
Staffing	**Metric 1:** Nursing facility maintains an additional four or more hours of registered nurse (RN) coverage per day beyond the CMS minimum standard (8 hrs/day). Does not include managerial hours. **Metric 2:** Nursing facility's per-resident day certified nursing assistants (CNAs), rehabilitation aid, and other contracted aid services are at or above one-half standard deviation above the statewide mean of per-resident-day CNA hours. CNA hours include those of CNAs, rehabilitation aid, and other contracted aide services. CNA hours will be normalized to remove variations in staff hours associated with different levels of resident case mix. **Metric 3:** Nursing facility's per-resident day total nursing hours are at or above one-half standard deviation above the statewide mean of per-resident-day total nursing hours. Nursing hours include those of RNs and licensed practical nurses (LPNs) including restorative nurses. Nursing hours will be normalized to remove variations in staff hours associated with different levels of resident case mix.	Staffing metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Payroll-based journal (PBJ) or cost reports
Infection Control	**Metric 1:** Nursing facility has an infection control program that includes antibiotic stewardship. The program incorporates policies and training as well as monitoring, documenting, and providing staff with feedback. **Metric 2:** Percentage of residents with urinary tract infections (UTIs) at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on minimum data set (MDS) data as applied to the nationally reported quality measures. **Metric 3:** Percentage of residents with up-to-date pneumonia vaccine measured against a fixed benchmark that is set as the most recently published national average for the related MDS quality metric.	Infection control metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Nursing facility will be required to provide its infection control policy and procedure. In addition, facilities will need to provide information regarding training, monitoring, documentation and monitoring of required elements to meet this metric on a periodic basis CASPER Report MDS Assessment Care Compare
Quality Measures	**Metric 1:** Percentage of high-risk residents with pressure ulcers (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. **Metric 2:** Percentage of residents who had a fall with major injury (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. **Metric 3:** Percentage of residents who received antipsychotic medications are at rates one-half	Quality measures metrics 1, 2, 3, and 4 must be met for the facility to be eligible for per diem rate add-on payment.	CASPER Report MDS Assessment Care Compare

	standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. **Metric 4:** Percentage of residents who required increased activities of daily living (ADL) assistance (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.		
State Survey Results	Number of deficiencies is at or below the state of Iowa average number of nursing facility deficiencies AND the facility has no deficiencies with a scope of F, H, I, J, K, or L.	State survey results must be met for the facility to be eligible for per diem rate add-on payment.	Department of inspections, appeals, and licensing (DIAL) surveys
Quality Assurance Performance Improvement (QAPI) Report	Nursing facility must submit QAPI reports on quarterly basis.	QAPI results must be submitted for the facility to be eligible for per diem rate add-on payment.	QAPI reports

(4) A provider must submit the Intent to Participate Agreement on or before September 30 each year and include all necessary documentation related to the quality measures.

1. Upon receipt of the participation agreement, the department will complete a determination of eligibility based on the care criteria defined above.

2. Providers will be notified of their eligibility annually within 60 days of the agreement due date.

(5) The nursing facility QIPP add-on rate provided to a participating NSGO nursing facility under the QIPP will not exceed Medicare payment principles pursuant to 42 CFR 447.272 (as amended to August 1, 2024) and will be calculated pursuant to 42 CFR 438.6 (as amended to August 1, 2024). The QIPP add-on rate will be calculated and paid as follows:

1. The methodology utilized to calculate the upper payment limit will be based on the data available during the calculation period.

2. The eligible amount used in determining the QIPP add-on rate will be the difference between the state Medicaid payment and the Medicare upper payment limit as determined, on an annual basis, using all Medicaid claims, including fee-for-service (FFS) and Medicaid managed care claims.

3. The difference calculated under numbered paragraph “2” will be divided by total patient days pursuant to subrule 81.5(7).

4. The QIPP add-on rate will be paid prospectively.

(6) A participating NSGO nursing facility shall notify the department of any change of ownership that may affect the participating NSGO nursing facility’s continued eligibility for the QIPP a minimum of 30 days prior to such change.

1. If a participating NSGO nursing facility changes ownership to a privately owned entity, on or after the first day of the QIPP add-on rate calculation period, the privately owned provider is no longer eligible for the QIPP add-on rate.

2. A participating facility must meet the CMS and department requirements to be classified as an NSGO nursing facility. All changes of ownership must be a fair market value transaction.

3. If it is determined that a provider is not a qualified NSGO nursing facility per CMS and the department, the provider shall repay all QIPP add-on payments to the department.

(7) Providers that do not meet eligibility requirements above will be notified of the metrics that were not met.

(8) A participating NSGO nursing facility shall secure allowable intergovernmental transfer funds from a participating NSGE to provide the state share amount. The process for the intergovernmental transfer shall comply with the following:

1. The department, or the department’s designee, will notify the participating NSGO nursing facility of the state share amount to be transferred in the form of an intergovernmental transfer for purposes of seeking federal financial participation for the QIPP add-on rate, within 15 business days after the end of

each month. The participating NSGO shall have until the end of the month to remit payment of the state share amount in the form of an intergovernmental transfer to the department or the department's designee.

2. If there is any outstanding intergovernmental transfer amount at the end of the payment period, the provider will not be able to participate in the QIPP the following year.

81.5(17) *Cost report documentation.* All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.5(18) *Inflation factor.* The department will consider an inflation factor in determining the reimbursement rate. The inflation factor will be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting will be used to determine the inflation factor.

81.5(19) *Case-mix index calculation.*

a. The RUG-III Version 5.12b, 34 group, index maximizer model will be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.12(9). Standard Version 5.12b case-mix indices developed by CMS will be the basis for calculating the average case-mix index and will be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.5(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment will be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group will be translated to the appropriate case-mix index referenced in paragraph *"a."* From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility will be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors will be excluded from both average case-mix index calculations.

81.5(20) *Medicare crossover claims for nursing facility services.*

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including but not limited to qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"Medicaid reimbursement" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

81.5(21) *Nursing facility quality assurance payments.*

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, a quality assurance assessment pass-through will be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through will equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, a quality assurance add-on of $37 per patient day will be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on the Nursing Facility Medicaid Enhanced Payment Report demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference will be used to increase compensation and costs of employment for direct care workers determined pursuant to Iowa Code section 249L.4.

(2) No less than 60 percent of the difference will be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to Iowa Code section 249L.4.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36 has been approved by CMS, none of the nursing facility rate-setting methodologies of this subrule will become effective.

e. End date. If CMS determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36 is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule will be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department will:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16 and chapters 249K and 249L.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.6(249A) Continued review.

81.6(1) *Level of care.* The department will review Medicaid members' need for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.2(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member's need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the department for all reviews that indicate a change in the member's level of care. The department will make a final determination for any reviews that indicate a change in the level of care.

81.6(2) *PASRR.* As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);

b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and

c. Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.2(3)*"b."*

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.7(249A) Records.

81.7(1) *Content.* The facility shall as a minimum maintain the following records:

a. All records required by the department and the department of inspections, appeals, and licensing.

b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident's records that will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care that have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents' personal records.

k. Residents' medical records.

l. Disaster preparedness reports.

81.7(2) *Retention.* Records identified in subrule 81.7(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.7(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.8(249A) Payment procedures.

81.8(1) *Method of payment.* Except for Medicaid accountability measures payment established in paragraph 81.5(16)*"g,"* facilities will be reimbursed under a modified price-based vendor payment program. A per diem rate will be established based on information submitted according to rule 441—81.5(249A). The per diem rate will include an amount for Medicaid accountability measures.

81.8(2) *Authorization of payment.* The department will authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.8(3) *Periods authorized for payment.*

a. Payment will be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for a visit, vacation, or hospitalization will be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which will be paid for such periods at 42 percent of the facility's rate.

g. Payment for residents determined by utilization review to require the residential level of care will be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

h. Ventilator patients.

(1) Definition. For purposes of this paragraph only, "ventilator patients" means Medicaid-eligible patients who, as determined by the quality improvement organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.

(2) Reimbursement. In-state nursing facilities will receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in subparagraph 81.5(16)*"f"*(3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.

i. Payment for residents of a special population facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that the department may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.

j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

(1) The wrong surgical or other invasive procedure is performed on a resident; or

(2) A surgical or other invasive procedure is performed on the wrong body part; or

(3) A surgical or other invasive procedure is performed on the wrong resident.

81.8(4) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the department as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—paragraph 78.10(2)*"d,"* medical supplies except for those listed in 441—paragraph 78.10(4)*"b,"* oxygen except under circumstances specified in 441—paragraph 78.10(2)*"a,"* and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician.

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The department will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)*"a"*(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident's family, or friends may pay to hold the resident's bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident's family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR 483.10 (as amended to August 1, 2024).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than 50 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall notify all residents, prospective residents, and their legal representatives in accordance with Iowa Code section 249A.4(10)*"b"*(1).

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record the information set forth in Iowa Code section 249A.4(10)*"b"*(2).

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

g. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.8(3)*"j"* and shall not discharge a resident due to nonpayment for such days.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.9(249A) Billing procedures. Claims for service must be sent to the department after the month of service and within 365 days of the date of service. Claims must be submitted electronically through the department's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the department. A request for an adjustment to a paid claim must be received by the department within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.10(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall

be approved by the resident's managed care organization or by the department for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.11(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department that sets forth the terms under which they will participate in the program.

81.11(1) *Procedures for establishing health care facilities as Medicaid facilities.* All survey procedures and certification process shall be in accordance with department of health and human services publication "State Operations Manual" (as amended to August 1, 2024).

81.11(2) *Medicaid provider agreements.*

a. The health care facility shall be recommended for certification by the department of inspections, appeals, and licensing for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with department of health and human services publication "Providers Certification State Operations Manual" as amended to August 1, 2024. The effective date of a provider agreement may not be earlier than the date of certification.

b. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

81.11(3) *Distinct part requirement.* All facilities that provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections, appeals, and licensing.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work there regularly. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.11(4) *Civil rights.* The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 (as amended to August 1, 2024) in all areas of administration including admissions, records, services and physical facilities, room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.11(5) *Resident rights.* The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident in accordance with 42 CFR 483.10 (as amended to August 1, 2024).

81.11(6) *Admission, transfer and discharge rights.*

a. Definition. Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

b. Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident, in accordance with 42 CFR 483.15 (as amended to August 1, 2024).

81.11(7) *Resident behavior and facility practices.*

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections, appeals, and licensing) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections, appeals, and licensing) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.11(8) *Quality of life.* A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life in accordance with 42 CFR 483.10 (as amended to August 1, 2024).

a. Activities. The facility shall provide for an ongoing program of activities designed to meet, based on the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident in accordance with 42 CFR 483.24(c) (as amended to August 1, 2024).

b. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis in accordance with 42 CFR 483.70(p) (as amended to August 1, 2024).

c. Environment. The facility shall provide a safe, clean, comfortable and homelike environment in accordance with 42 CFR 483.10(i) (as amended to August 1, 2024).

81.11(9) *Resident assessment.* The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability in accordance with 42 CFR 483.20(a) through (j) (as amended to August 1, 2024).

a. Use of independent assessors. If the department or the department of inspections, appeals, and licensing determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements in a resident assessment, the department or the department of inspections, appeals, and licensing may require that resident assessments under this paragraph be conducted and certified by

individuals who are independent of the facility and who are approved by the department or the department of inspections, appeals, and licensing for a period specified by the agency.

b. Comprehensive care plans. The facility shall develop a comprehensive care plan for each resident in accordance with 42 CFR 483.21(b) (as amended to August 1, 2024).

c. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary in accordance with 42 CFR 483.21(c)(2) (as amended to August 1, 2024).

d. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.11(10) *Quality of care.* Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A facility shall ensure that residents receive treatment in accordance with 42 CFR 483.24 and 483.25 (as amended to August 1, 2024).

a. Behavioral health services. Based on the comprehensive assessment of a resident, the facility shall ensure that residents receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with 42 CFR 483.40 (as amended to August 1, 2024).

b. Unnecessary drugs. Each resident's drug regimen shall be free from unnecessary drugs in accordance with 42 CFR 483.45(d) and (e) (as amended to August 1, 2024).

c. Medication errors. The facility shall ensure that it meets the standards set forth in 42 CFR 483.45(f) (amended to August 1, 2024).

81.11(11) *Nursing services.* In accordance with 42 CFR 483.35 (as amended to August 1, 2024), the facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

81.11(12) *Dietary services.* In accordance with 42 CFR 483.60 (as amended to August 1, 2024), the facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

81.11(13) *Physician services.* In accordance with 42 CFR 483.30 (as amended to August 1, 2024), a physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

81.11(14) *Specialized services.* When indicated, specialized services shall be provided to residents as follows:

a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician in accordance with 42 CFR 483.65 (as amended to August 1, 2024).

b. Specialized services for mental illness. "Specialized services for mental illness" means services provided in response to an exacerbation of a resident's mental illness that:

(1) Are beyond the normal scope and intensity of nursing facility responsibility;

(2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

(3) Are provided through a professionally developed plan of care with specific goals and interventions;

(4) May be provided only by a specialized licensed or certified practitioner;

(5) Are expected to result in specific, identified improvements in the resident's psychiatric status to the level before the exacerbation of the resident's mental illness; and

(6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident's diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service that is available for which the member meets eligibility criteria.

c. Specialized services for intellectual disability. "Specialized services for intellectual disability" means services that:

(1) Are beyond the normal scope and intensity of nursing facility responsibility;

(2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

(3) Are provided through a professionally developed plan of care with specific goals and interventions;

(4) Must be supervised by a qualified intellectual disability professional; and

(5) May include:

1. A functional assessment of maladaptive behaviors.

2. Development and implementation of a behavioral support plan.

3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.11(15) *Dental services.* In accordance with 42 CFR 483.55 (as amended to August 1, 2024), the facility shall assist residents in obtaining routine and 24-hour emergency dental care.

81.11(16) *Pharmacy services.* In accordance with 42 CFR 483.45 (as amended to August 1, 2024), the facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

81.11(17) *Infection control.* In accordance with 42 CFR 483.80 (as amended to August 1, 2024), the facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

81.11(18) *Physical environment.* In accordance with 42 CFR 483.90 (as amended to August 1, 2024), the facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

81.11(19) *Administration.* In accordance with 42 CFR 483.70(a) through (d) (as amended to August 1, 2024), a facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Required training of nurse aides.

(1) Definitions.

"Licensed health professional" means a physician; physician associate; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

"Nurse aide" means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis in accordance with the exceptions and provisions specified in 42 CFR 483.25(d) (as amended to August 1, 2024).

b. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

c. Staff qualifications. Staff qualifications must be met in accordance with 42 CFR 483.70(f) (as amended to August 1, 2024).

d. Use of outside resources. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in 42 CFR 483.70(g) (as amended to August 1, 2024).

e. Medical director. The facility shall designate a physician to serve as medical director in accordance with 42 CFR 483.70(h) (as amended to August 1, 2024).

f. Laboratory, radiology, and other diagnostic services. The facility shall provide or obtain clinical laboratory, radiology, and other diagnostic services to meet the needs of its residents in accordance with 42 CFR 483.50 (as amended to August 1, 2024).

g. Clinical records. The facility shall maintain clinical records on each resident in accordance with 42 CFR 483.70(i) (as amended to August 1, 2024).

h. Disaster and emergency preparedness.

(1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

i. Transfer agreement. The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs in accordance with 42 CFR 483.70(j) (as amended to August 1, 2024).

j. Quality assessment and assurance. A facility shall maintain a quality assessment and assurance committee in accordance with 42 CFR 483.75(g) through (i) (as amended to August 1, 2024).

k. Disclosure of ownership.

(1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104 (as amended to August 1, 2024).

(2) The facility shall provide written notice to the department of inspections, appeals, and licensure at the time of change, if a change occurs in:

1. Persons with an ownership or control interest.
2. The officers, directors, agents, or managing employees.
3. The corporation, association, or other company responsible for the management of the facility.
4. The facility's administrator or director of nursing.

(3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—81.12(249A) Audits.

81.12(1) *Audit of financial and statistical report.* Authorized representatives of the department or the U.S. Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report are reasonable and proper according to the rules set forth in rule 441—81.5(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items that had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to

the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.12(2) *Audit of proper billing and handling of patient funds.*

a. The department; the department's contracted managed care organizations; field auditors of the department of inspections, appeals, and licensing; and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The department; the department's contracted managed care organizations; field auditors of the department of inspections, appeals, and licensing; and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.3(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation indicating that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph *"d,"* the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit that are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)*"a,"* and 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.13(249A) Nurse aide requirements and training and testing programs.

81.13(1) *Deemed meeting of requirements.* A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation approved by the department of inspections, appeals, and licensing if:

a. The nurse aide successfully completed a nurse aide training and competency evaluation program before July 1, 1989, and

(1) At least 60 clock hours were substituted for 75 clock hours, and the person has made up at least the difference in the number of clock hours in the program the person completed and 75 clock hours in supervised practical nurse aide training or in regular in-service nurse aide education, or

(2) The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 clock hours' duration, or

(3) The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989, or

(4) The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections, appeals, and licensing determines would have met the requirements for approval at the time it was offered; or

b. The person is a veteran, an active duty service member, or a member of the reserve forces, who has:

(1) Successfully completed a U.S. military training program that includes a curriculum comparable to the nurse aide training program required by this rule and has documented successful completion of that program with either a diploma, certifications, or Form DD 214 showing completion of hospital corpsman or medical service specialist or equivalent training, and

(2) Provided documentation showing that the person has 75 clock hours of practical experience in a nurse aide role, which may include classroom instruction, prior equivalent experience, or a combination of the two, and

(3) Successfully completed the nurse aide training and competency examination.

81.13(2) *State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.*

a. The department of inspections, appeals, and licensing will, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of paragraph 81.11(19)*"b"* and subrule 81.13(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections, appeals, and licensing approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections, appeals, and licensing will determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of subrule 81.13(3).
2. A nurse aide competency evaluation program meets the requirements of subrule 81.13(4).

(2) Except as provided by paragraph 81.13(2)*"f,"* the department of inspections, appeals, and licensing will not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility that, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or
2. Has been subject to an extended or partial extended survey; or
3. Has been assessed a civil money penalty of not less than $5,000; or
4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or
5. Pursuant to state action, was closed or had its residents transferred; or
6. Has been terminated from participation in the Medicaid or Medicare program; or
7. Has been denied payment.

c. Application process. Applications shall be submitted to the department of inspections, appeals, and licensing before a new program begins and every two years thereafter on a form prescribed by the department. The department of inspections, appeals, and licensing will, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections, appeals, and licensing will not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections, appeals, and licensing and the department of inspections, appeals, and licensing will review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval. The department of inspection, appeals, and licensing will follow the provision of 42 CFR 483.151(e) (as amended to August 1, 2024) regarding withdrawals of approvals.

f. An exception to subparagraph 81.13(2)*"b"*(2) may be granted by the department of inspections, appeals, and licensing for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted a Nurse Aide Education Program Waiver Request, to the department of inspections, appeals, and licensing to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved NATCEP.

(3) No other NATCEP is offered within ten minutes' travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by the department of inspections, appeals, and licensing.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the department of inspections, appeals, and licensing indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the department of inspections, appeals, and licensing to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP that shall return the evaluations to department of inspections, appeals, and licensing.

81.13(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections, appeals, and licensing to approve required nurse aide training and competency evaluation programs. Policies and procedures governing approval of the programs are set forth in 42 CFR 483.152 (as amended to August 1, 2024).

a. If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

(1) Add all costs incurred by the nurse aide for the course, books, and competency evaluations.

(2) Divide the total arrived at in subparagraph (1) above by 12 to prorate the costs over a one-year period and establish a monthly rate.

(3) The nurse aide shall be reimbursed the monthly rate each month the nurse aide works at the facility until one year from the time the nurse aide completed the course.

b. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.

c. Records and reports. Nurse aide education programs approved by the department of inspections, appeals, and licensing shall:

(1) Notify the department of inspections, appeals, and licensing:

1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.
2. When a facility or other training entity will no longer be offering nurse aide training courses.
3. Whenever the person coordinating the training program is hired or terminates employment.

(2) Keep a list of faculty members and their qualifications available for department review.

(3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.

(4) Complete a lesson plan for each unit that includes behavioral objectives, a topic outline and student activities and experiences.

(5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.13(4) *Nurse aide competency evaluation.* Nurse aid competency evaluation program shall be administered in accordance with 42 CFR 483.154 (as amended to August 1, 2024).

a. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

b. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas that the person did not pass.
2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

c. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

d. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections, appeals, and licensing. The department of inspections, appeals, and licensing shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.13(5) *Registry of nurse aides.*

a. Establishment of registry. The department of inspections, appeals, and licensing shall establish and maintain a registry of nurse aides in accordance with 42 CFR 483.156 (as amended to August 1, 2024). In addition, the registry shall contain a record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment, or misappropriation of resident property.

b. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry.

(1) Persons employed as nurse aides shall complete the Nurse Aide Registry Application within the first 30 days of employment. This form shall be submitted to the department of inspections, appeals, and licensing. The application may be obtained by telephone or by electronic request from the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed application to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, an electronic notification will be sent to the nurse aide that includes the registry ID number for the nurse aide to use when accessing the online registry. A nurse aide may obtain a copy of the information on the registry by accessing the information on the registry database.

81.13(6) *Hearing.* When there is an allegation of abuse against a nurse aide, the department of inspections, appeals, and licensing will investigate that allegation. When the investigation makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections, appeals, and licensing. The hearing shall be held pursuant to 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.13(7) *Appeals.* Adverse decisions made by the department of inspections, appeals, and licensing in administering these rules may be appealed pursuant to 481—Chapter 10.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25; **ARC 9859C**, IAB 12/24/25, effective 2/1/26]

441—81.14(249A) Sanctions.

81.14(1) *Penalty for falsification of a resident assessment.* An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty in accordance with 42 CFR 483.20(j) (as amended to August 1, 2024).

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections, appeals, and licensing or the director's designee may consider evidence of the circumstances surrounding the violation, including but not limited to the following factors:

(1) The number of assessments willingly and knowingly falsified.

(2) The history of the individual relative to previous assessment falsifications.

(3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.

(4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.

(5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections, appeals, and licensing in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections, appeals, and licensing may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.14(2) *Use of independent assessors.* If the department of inspections, appeals, and licensing determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections, appeals, and licensing may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

(1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.

(2) The facility's response to the falsification of or causing resident assessments to be falsified.

(3) The method used to prepare facility staff to do resident assessments.

(4) The number of individuals involved in the falsification.

(5) The number of falsified resident assessments.

(6) The extent of harm to residents caused by the falsifications.

b. The department of inspections, appeals, and licensing will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections, appeals, and licensing before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections, appeals, and licensing for completing its own assessments.

(3) The department of inspections, appeals, and licensing will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections, appeals, and licensing within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision that may be appealed to the director of the department of inspections, appeals, and licensing pursuant to 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.14(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed $2,000.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.15(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.15(1) Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state government owned nursing facility direct care rate component limit pursuant to subparagraph 81.5(16)*"f"*(1) plus the non-direct care rate limit pursuant to subparagraph 81.5(16)*"f"*(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.5(16)*"f"*(3) plus the non-direct care rate component limit pursuant to subparagraph 81.5(16)*"f"*(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident's health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.5(16)*"e"*(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident's health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.15(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.5(249A).

81.15(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.16(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, chapter 267, section 132(1)*"i."*

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.17(249A) Rates for Medicaid eligibles.

81.17(1) *Maximum client participation.* A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule 441—81.5(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.17(2) *Beginning date of payment.* When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident's Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident's client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.18(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than $55 per month shall receive a state-funded payment from the department for the difference between that countable income and $55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25; **ARC 9859C**, IAB 12/24/25, effective 2/1/26]

441—81.19(249A) Enforcement of compliance. Enforcement of compliance with this chapter shall occur in accordance with 42 CFR 488 (as amended to August 1, 2024).

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.20(249A) Appeal of a determination of noncompliance.

81.20(1) A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections, appeals, and licensing within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

a. A request for a hearing shall be made in writing to the department of inspections, appeals, and licensing within 60 days from receipt of the notice.

b. Hearings shall be conducted pursuant to 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections, appeals, and licensing as the final decision maker, with subject matter jurisdiction.

81.20(2) A facility may not appeal the choice of remedy, including the factors considered by the department of inspection, appeals, and licensing in selecting the remedy.

81.20(3) A facility may not challenge the level of noncompliance found by the department of inspections, appeals, and licensing, except that in the case of a civil money penalty, a facility may

challenge the level of noncompliance found by the department of inspections, appeals, and licensing only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

81.20(4) Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.21(249A) Civil money penalties—when penalty is collected. The collection of civil money penalties is made as provided in rule 441—81.24(249A).

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.22(249A) Civil money penalties—settlement authority. The department of inspections, appeals, and licensing has the authority to settle cases at any time before an evidentiary hearing.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.23(249A) Civil money penalties—deduction of penalty from amount owed.

81.23(1) The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.23(2) Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

441—81.24(249A) Use of penalties collected by the department. Civil money penalties collected by the department will be applied to the protection of the health or property of residents of facilities that the department of inspections, appeals, and licensing finds deficient. Funds may be used for:

1. Time-limited expenses incurred in the process of relocating residents to home- and community-based settings or other facilities when a facility is closed or downsized pursuant to an agreement with the department;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Support and protection of residents of a facility that closes;
4. Funding of projects to improve the quality of life and quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166;
5. Projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities; and
6. Reasonable expenses incurred by the department to administer, monitor, or evaluate the effectiveness of grants utilizing civil money penalty funds.

[**ARC 9279C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 249A.4.

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[1] Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.

[1] Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.

[1] Effective date of 81.13(7)*"c"*(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.

[1] Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.

[1] At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR PERSONS WITH AN INTELLECTUAL DISABILITY

[Prior to 7/1/83, Social Services[770] Ch 82]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

441—82.1(249A) Definitions.

"Intermediate care facility for persons with an intellectual disability" or *"ICF/ID"* means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as amended to August 1, 2024; or has a related condition as defined in 42 CFR 435.1009 as amended to August 1, 2024; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermediate care facility for persons with medical complexity" means an intermediate care facility for persons with an intellectual disability that provides health and rehabilitation services to individuals who require a skilled nursing level of care, have either a multiple organ dysfunction or severe single organ dysfunction, and require daily use of medical resources or technology.

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

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as an intermediate care facility for persons with an intellectual disability by the department of inspections, appeals, and licensing pursuant to 481—Chapter 64. The facility shall meet the following conditions of participation.

82.2(1) *Governing body and management—disclosure of ownership.* The facility shall supply to the licensing agency full and complete information, and promptly report any changes that would affect the current accuracy of the information, as to identify:

a. Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

b. Each officer and director of the corporation if the facility is organized as a corporation.

c. Each partner if the facility is organized as a partnership.

82.2(2) *Client protections.* The facility shall ensure the rights of all clients in accordance with 42 CFR 483.420 as amended to August 1, 2024.

82.2(3) *Facility staffing.* The facility shall provide adequate, qualified professional staffing in accordance with 42 CFR 483.430 as amended to August 1, 2024.

82.2(4) *Active treatment services.* Each client shall receive a continuous active treatment program in accordance with 42 CFR 483.440 as amended to August 1, 2024.

82.2(5) *Client behavior and facility practices.* Each facility shall establish and maintain standards for client behavior and facility practices in accordance with 42 CFR 483.450 as amended to August 1, 2024.

82.2(6) *Health care services.* Each facility shall establish and maintain standards for health care services in accordance with 42 CFR 483.460 as amended to August 1, 2024.

82.2(7) *Physical environment.* Each facility shall establish and maintain standards for the physical environment in accordance with 42 CFR 483.470 as amended to August 1, 2024.

82.2(8) *Dietetic services.* Each facility shall establish and maintain standards for dietary services in accordance with 42 CFR 483.480 as amended to August 1, 2024.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability. All intermediate care facilities for persons with an intellectual disability must enter into a contractual agreement with the department that sets forth the terms under which they will participate in the program.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.4(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a financial and statistical report to the department. These reports shall be based on the following rules.

82.4(1) *Failure to maintain records.* Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.4(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities that are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.4(3) *Submission of reports.* The facility's cost report shall be received by the department no later than September 30 each year except as described in subrule 82.4(14).

a. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the department to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 82.4(3)*"c."*

b. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 and shall remain in effect until the first day of the month after the delinquent report is received by the department.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the department.

d. Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability continues to include in the total costs an item or items that had in a prior period been removed through an adjustment made

by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the department can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

f. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

82.4(4) *Payment at new rate.* When a new rate is established, payment at the new rate will be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments will be included in the payment the third month after the receipt of the report.

82.4(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses pertaining to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.4(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.4(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.4(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.4(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.4(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services that include room, board, nursing services, and such services as supervision, feeding, incontinence, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services that are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.4(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules:

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid to directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation includes all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the department. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation are unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, are required to be reported to the department with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 82.4(3)*"c."*

(2) Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is $1,926 per month plus $20.53 per month per licensed bed capacity for each bed over 60, not to exceed $2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators will be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.4(11)*"e"*(4) through 82.4(11)*"e"*(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit will be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

f. Management fees and home office costs are allowed only to the extent they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (2023 edition), may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment will be made. For change of ownership, refer to subrule 82.4(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) Necessary requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants, whether restricted or unrestricted, and that are held separate and not commingled with other funds.

(3) Proper requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

i. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those that commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

(1) When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report is the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return is defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

(2) When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report is limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

(3) The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility that supplies transportation services as defined in Iowa Code section 324A.1(1) shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, will result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Reserved.

m. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. However, facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

n. Penalties or fines imposed by federal or state agencies are not allowable expenses.

o. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

82.4(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership that is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership that is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion but terminates with respect to the leased portion.

b. No increase in the value of the property is allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property are not allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act (as amended to August 1, 2024) regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation that verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

82.4(13) *Assessed fee.* The fee assessed pursuant to 441—Chapter 36 is not an allowable cost for cost reporting and audit purposes. In lieu of treating the fee as an allowable cost, a per diem assessment amount is added to the reimbursement rate calculated under subrule 82.4(14), not subject to the maximum allowable base cost or maximum rate set at the eightieth percentile. The per diem assessment amount will be calculated by dividing the annual assessment paid by the reported total patient days.

82.4(14) *Payment to new facility.* A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, is subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility will be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate will be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate will be adjusted July 1 of each year. The state hospital schools are not to be included in the compilation of facility costs. The beginning rates for a new facility will be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges that have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include but are not limited to legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 through June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 through June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 through June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 through June 30.

(3) All facilities shall comply with the requirements of subrule 82.4(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.4(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under

contract with the department. Based on the audited cost report, a rate will be established for the facility. This rate will be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities will be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/ID with established base rates. The eightieth percentile maximum rate will be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities that complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.4(14)*"d,"* will be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility will receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates will be subject to the prevailing maximum rate.

82.4(15) *Payment to new owner.* An existing facility with a new owner will continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.4(16). The facility may submit a report for the period of July 1 through June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.4(16) *Payment to existing facilities.* The following reimbursement limits apply to all non-state-owned ICFs/ID:

a. Each facility shall file a cost report covering the period from January 1, 1992, through June 30, 1992. This cost report will be used to establish a reimbursement rate to be paid to the facility and will be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 through June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, through June 30, 1992, will be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, through June 30, 1992, cost report will become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.4(14)*"d."*

d. Facilities that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index will be given their actual percentage increase plus one-half the difference of

their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year will receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include but are not necessarily limited to the administrative portion of the following:

(1) Administrator wages.
(2) Business office wages.
(3) Advertising and marketing wages.
(4) Employer's taxes (administrative).
(5) Group/life and retirement benefits (administrative staff).
(6) Workers' compensation insurance (administrative staff).
(7) Employment advertising and recruitment (administrative staff).
(8) Criminal record checks (administrative staff).
(9) Education and training (administrative staff).
(10) Office supplies (administrative staff).
(11) Telephone.
(12) Equipment rental.
(13) Home office costs.
(14) Management fees.
(15) Accounting fees.
(16) Professional organization dues.
(17) Licensing fees.
(18) Information technology expenses.
(19) Legal fees—direct patient-care-related.
(20) Legal fees—other.
(21) Working capital interest.
(22) General liability insurance.
(23) Travel, entertainment and auto expenses.
(24) Advertising and public relations.
(25) Other.

f. Facility rates will be rebased using the cost report for the year covering state fiscal year 1996 and will subsequently be rebased each four years. The department will consider allowing special rate adjustments between rebasing cycles if:

(1) An increase in the minimum wage occurs.

(2) A change in federal regulations occurs that necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes that necessitate the addition of staff or other resources.

(3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).

(4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation are inpatient days as determined in subrule 82.4(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate will be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase that will not exceed the percentage change in the Consumer Price Index.

h. State-owned ICFs/ID shall submit annual cost reports and will receive annual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility will receive as reimbursement in the following period the maximum allowable base as calculated.

82.4(17) *Wage add-on factor.* A wage add-on factor of $8.86 per day for community-based ICFs/ID will be included in rates effective July 1, 2022, and after, not subject to the maximum allowable cost ceiling in paragraph 82.4(14)*"e,"* until rates are established using the cost reports for the period ending June 30, 2023.

a. In accordance with 2022 Iowa Acts, House File 2578, section 31, the entire wage add-on factor will be used for wages and associated costs specific to wages, benefits, and required withholding of direct support professionals and frontline management.

b. The wage add-on factor of $8.86 per day will be added to the maximum allowable base rate in subparagraph 82.4(14)*"d"*(1) until the next rebase using cost reports for the period ending June 30, 2024.

c. The wage add-on factor of $8.86 per day will be added to the maximum allowable cost ceiling, eightieth percentile of costs of all participating facilities in paragraph 82.4(14)*"e,"* until the eightieth percentile maximum is established using the December 31, 2023, compilation for rates effective beginning July 1, 2024.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.5(249A) Eligibility for services.

82.5(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

82.5(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for persons with an intellectual disability services are required by an individual whose needs might be met through the use of alternative services that are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.5(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must

be obtained from the managed care organization prior to admission. Eligibility will continue as long as a valid need for the care exists.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.6(249A) Initial approval for ICF/ID care.

82.6(1) *Referral through targeted case management.* Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program will:

a. Identify appropriate service alternatives;

b. Inform the person of the alternatives; and

c. Refer a person without appropriate alternatives to the department.

82.6(2) *Approval of placement by department.*

a. Within 30 days of receipt of a referral, the department will:

(1) Approve ICF/ID placement;

(2) Offer a home- or community-based alternative; or

(3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.6(3), the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

82.6(3) *Approval of level of care.* Medicaid payment will be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the department.

82.6(4) *Appeal rights.* Notice of adverse action and right to appeal will be given in accordance with rule 441—16.3(17A) and 441—Chapter 2506.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

441—82.7(249A) Determination of need for continued stay. For clients not enrolled with a managed care organization, certification of need for continued stay will be made according to procedures established by the department. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client's need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the department for all reviews that indicate a change in the client's level of care. The department will make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.8(249A) Arrangements with residents.

82.8(1) *Resident care agreement.* The ICF/ID Resident Care Agreement shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.8(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

82.8(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility.

The accounting system is subject to audit by representatives of the department of inspections, appeals, and licensing and will meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections, appeals, and licensing representative. Audit certification will be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department will turn the funds over to the member's estate.

82.8(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.9(249A) Discharge and transfer.

82.9(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.9(2) *Case activity report.* A case activity report shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.9(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.9(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's or qualified intellectual disability professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.9(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.10(249A) Records.

82.10(1) *Content.* The facility shall at a minimum maintain the following records:

a. All records required by the department and the department of inspections, appeals, and licensing.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act (as amended to August 1, 2024).

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records, which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care that have not been properly accounted for.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.10(2) *Retention.* Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.10(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.11(249A) Payment procedures.

82.11(1) *Method of payment.* Facilities will be reimbursed under a cost-related vendor payment program. A per diem rate will be established based on information submitted according to rule 441—82.4(249A).

82.11(2) *Periods authorized for payment.*

a. Payment will be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for persons with an intellectual disability.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.11(3) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person. However, the resident or the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over ten days on a hospital stay. When the resident is not discharged from the facility, the payments will not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.12(249A) Billing procedures. Claims for service for clients not enrolled with a managed care organization must be sent to the department after the month of service and within 365 days of the date of service. Such claims must be submitted electronically through the department's electronic clearinghouse.

82.12(1) A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

82.12(2) Adjustments to claims may be made electronically as provided for by the department.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.13(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the resident's managed care organization or by the department for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.14(249A) Audits.

82.14(1) *Audits of financial and statistical report.* Authorized representatives of the department or the U.S. Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the financial and statistical report are reasonable and proper according to the rules set forth in 441—82.4(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent financial and statistical report, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items that had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.14(2) *Auditing of proper billing and handling of patient funds.*

a. The department, the department's contracted managed care organizations, field auditors of the department of inspections, appeals and licensing and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The department, the department's contracted managed care organizations, field auditors of the department of inspections, appeals, and licensing and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.8(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation that would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph 82.14(2)*"d,"* the requested refunds may be withheld from future payments to the facility. The withholding will not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding will continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit that are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.15(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.15(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.15(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.56(249A).

82.15(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds will be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 9066C**, IAB 4/2/25, effective 6/1/25]

441—82.16(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than $55 per month will receive a state-funded payment from the department for the difference between that countable income and $55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

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◊ Two or more ARCs

CHAPTER 83
MEDICAID WAIVER SERVICES

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

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

"Blind" means an individual has a central visual acuity of 20/200 or less in the better eye with the use of a corrective lens or visual field restriction to 20 degrees or less.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Disabled" means an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Guardian" means a guardian appointed in probate court.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in DSM-5 or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

"Medical assessment" means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility or an intermediate care facility for persons with an intellectual disability that has been approved as a Medicaid vendor.

"Medical intervention" means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member's care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member's plan of care.

"Member" means an individual who has been determined to be eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, the member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Substantial gainful activity" means productive activities that add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payment" means payment from an attorney, individual, institution, corporation, or public or private agency that is 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 or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act as amended to July 1, 2026.

b. Reserved.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC and the interRAI - HC are available upon request from Iowa Medicaid. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1)*"b."*

(2) Iowa Medicaid will be responsible for the initial determination of the member's level of care certification. Iowa Medicaid or the member's MCO will be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. Iowa Medicaid will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the member must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

(3) Residing in the member's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician associate.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified in 441—paragraphs 75.82(2)*"b"* and 75.82(4)*"c"* will be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The member shall have a service plan approved by the department that is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager will establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan will be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1)*"d"* and other supporting documentation as relevant. The designated case manager will have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services will not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/ID
$3,166.53	$1,087.96	$4,244.04

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) will be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member's case manager no earlier than two months before, and no later than six months after, the member's twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member's waiver budget will be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted MCO during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department will determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services will become effective on the later of the first day of the month of the member's twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget will extend up to the first of the month following the member's twenty-fifth birthday and will remain at the initially authorized amount for the member while aged 21 through 24.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training will be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search will be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver will be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name will be placed on a waiting list maintained by Iowa Medicaid.

a. The department field office will enter all waiver applications into the institutional and waiver service and narrative system (IoWANS) to determine whether a payment slot is available.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed application for health coverage and help paying costs or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot will be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the department field office will give written notice to the applicant. The department will hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department will enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the waiting list on the basis of the date a completed application for health coverage and help paying costs is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid will be added to the waiting list on the basis of the date a request as specified in subparagraph 83.3(2)*"a"*(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots will have their application rejected, and their names will be maintained on the waiting list. They will be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. Iowa Medicaid will contact the department field office when a slot becomes available.

(5) Once a payment slot is assigned, the department field office will give written notice to the person within five working days. The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The department field office will notify Iowa Medicaid within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program will be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information that is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to Iowa Medicaid.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application will be denied.

b. Decisions will be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services will not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility will be effective on the date the income and resource eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)*"a"* and *"c"* do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1)*"c"*(3) will exist on the date the income and resource eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual will be computed by deducting an amount that is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid will make no payments to health and disability waiver service providers. However, Medicaid will make payments to other medical vendors, as applicable.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's

situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.17(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.5(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1)*"b."* Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers that will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.8(249A) Adverse service actions.

83.8(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in paragraph 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in paragraph 83.2(2)*"b."*

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member's own home as determined by the designated case manager.

e. Service providers are not available.

83.8(3) *Reduction.* Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.9(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 2506.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.10 to **83.20** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Basic individual respite" means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Guardian" means a guardian appointed in probate court.

"Interdisciplinary team" means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

"Medical institution" means a nursing facility that has been approved as a Medicaid vendor.

"Member" means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an individual, institution, corporation, or public or private agency that is 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 or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified in 441—paragraphs 75.82(2)*"b"* and 75.82(4)*"c"* will be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - HC is available on request from the department and other supporting documentation as relevant. Copies of the completed interRAI - HC for an individual are available to that individual from the individual's case manager or MCO.

(1) The assessment will be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care. The department will be responsible for determination of the initial level of care.

(2) The department or the member's MCO will be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. For the consumer choices option as set forth in 441—subrule 78.34(13), residing in a living arrangement other than a residential care facility.

83.22(2) *Need for services, service plan, and cost.*

a. Case management. Members under the elderly waiver will receive case management services from a provider qualified pursuant to rule 441—77.38(249A). Case management services will be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Interdisciplinary team. The case manager will establish an interdisciplinary team for the member.

(1) Composition. The interdisciplinary team will include the case manager and the member and, if appropriate, the member's legal representative, family, service providers, and others directly involved in the member's care.

(2) Role. The team will identify:

1. The member's need for services based on the member's needs and desires.
2. Available and appropriate services to meet the member's needs.
3. Health and safety issues for the member that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the member's needs change.

c. Service plan. An applicant for elderly waiver services will have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan will be appropriate to the problems and specific needs or disabilities of the member.

(2) Services must be the least costly available to meet the service needs of the member.

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the member's needs.

d. Content of service plan. The service plan will include the following information based on the member's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the member received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
2. The funding source for the service.
3. The amount of service that the member is to receive.

(9) Indication of whether the member has elected the consumer choice option and, if so, the independent support broker and the financial management service that the member has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the member in situations for which no approved service plan exists and that, if not addressed, may result in injury or harm to the member or other persons or in significant amounts of property damage. Emergency plans will include:

1. The member's risk assessment and the health and safety issues identified by the member's interdisciplinary team.
2. The emergency backup support and crisis response system identified by the interdisciplinary team.
3. Emergency, backup staff designated by providers for applicable services.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.23(2) *Approval of application.*

a. Applications for the elderly waiver program will be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision will be made as soon as possible.

b. Decisions will be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in paragraph 83.22(1)*"d,"* indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(3) *Effective date of eligibility.*

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines will not exist until the persons require care in a medical institution for a period of 30 consecutive days and will be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the individual that is 300 percent of the maximum supplemental security income (SSI) grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services will be done at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination will contain the components listed in rule 441—83.27(249A).

83.25(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.25(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).
[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.27(249A) Service plan. The service plan will be completed jointly by the member, the elderly waiver case manager, and any other person identified by the member.

83.27(1) The service plan will indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan will identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.27(2) The service plan will identify a plan for emergencies and the supports available to the member in an emergency.
[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs are not met by services provided.

d. Needed services are not available or received from qualifying providers.

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.

c. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the case manager and the interdisciplinary team.

d. Service providers are not available.

83.28(3) *Reduction.* Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*
[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.29(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 2506.
[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management will cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services will be used.
[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.31 to **83.40** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"Basic individual respite" means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the services or the program in which the member is enrolled.

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Guardian" means a guardian appointed in probate court.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

"Medical institution" means a nursing facility or hospital that has been approved as a Medicaid vendor.

"Member" means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.

- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an attorney, individual, institution, corporation, or public or private agency that is 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 or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC, and the interRAI - HC are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) The assessment as listed in paragraph 83.42(1)*"b"* will be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care.

(2) The department will be responsible for approval of the certification of the level of care, and the department or an MCO will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services will not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income that does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) *Need for services.*

a. The designated case manager will review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This review will be based, in part, on information in the completed information submission tool designated in paragraph 83.42(1)*"b"* and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services will not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $2,128.08.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.43(2) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program will be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information that is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the department.

b. Decisions will be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the member service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(3) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—paragraph 75.6(4)*"b"* and rule 441—75.82(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive days for other than respite care will be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through a notice of decision. If the member returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but will not be earlier than the first of the month following the date of application.

83.43(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual will be computed by deducting an amount that is 300 percent of the maximum monthly payment for one person under SSI from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services will be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors will be made in accordance with rules 441—76.17(249A) and 441—83.42(249A). A redetermination will include the components listed in rule 441—83.47(249A).

83.45(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.45(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.47(249A) Service plan. A service plan will be prepared for AIDS/HIV waiver members in accordance with rule 441—130.7(234) except that service plans for both children and adults will be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan will include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan will indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan will identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.47(3) Service plans for members aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan will identify a plan for emergencies and the supports available to the member in an emergency.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.48(249A) Adverse service actions.

83.48(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in paragraph 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) *Termination.* Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in paragraph 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) *Reduction.* Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.49(249A) Appeal rights. Notice of adverse action shall be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 2506.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.50 to **83.59** Reserved.

These rules are intended to implement Iowa Code section 249A.4.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with an intellectual disability aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

"Basic individual respite" means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management" means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

"Case manager" means the staff person providing all categories of case management services regardless of the entity providing the services or the program in which the member is enrolled.

"Child" means a person with an intellectual disability aged 17 or under.

"Client participation" means the posteligibility amount of the member's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Counseling" means face-to-face mental health services provided to the member and caregiver by a QIDP to facilitate home management of the member and prevent institutionalization.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Direct service" means services involving face-to-face assistance to a member such as transporting a member or providing therapy.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) that will be made only when the onset of the person's condition was during the developmental

period and will be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. The diagnosis shall be made in accordance with the criteria provided in DSM-5.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in DSM-5 or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

"Medical assessment" means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"Medical intervention" means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member's care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member's plan of care.

"Member" means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

"Organization" means the entity being certified.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified intellectual disability professional" or *"QIDP"* means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the National Board for Certification in Occupational Therapy or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master's degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the Academy of Nutrition and Dietetics.
10. A human services professional who must have at least a bachelor's degree in a human services field, including but not limited to sociology, special education, rehabilitation counseling and psychology.

"Related condition" means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payment" means payment from an attorney, individual, institution, corporation, insurance company, or public or private agency that is 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 or a past or present recipient of Medicaid.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The department will be responsible for the initial approval, and the department or an MCO will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a member must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

i. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

j. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

k. To be eligible for interim medical monitoring and treatment services the member must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

(3) Residing in the member's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician associate.

l. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

m. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the department. Requests for approval shall be submitted in writing to the department and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)*"a"*; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

n. For day habilitation, be 16 years of age or older.

o. For the consumer choices option as set forth in 441—subrule 78.41(15), not be living in a residential care facility.

83.61(2) *Need for services.*

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of the interRAI assessment tool.

b. Applicants not receiving services as set forth in paragraph 83.61(2)*"a"* shall have a department service worker or case manager:

(1) Arrange for completion of the interRAI assessment tool for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager will be referred to a Medicaid case manager.

d. Services will not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests will only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of an interRAI assessment tool for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager's control.

g. At initial enrollment, the case manager will establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager will complete an annual review thereafter. The following criteria will be used for the initial and ongoing identification of need for services:

(1) The assessment will be based on the results of the most recent interRAI assessment or the off-year assessment tool.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 16 or under which include supported community living services beyond intermittent will be approved (signed and dated) by the department. The service worker, department QIDP, or Medicaid case manager will attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance will provide a rationale for requesting supported community living beyond intermittent. The rationale will contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state will be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department will make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots will be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list will be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department will determine whether a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot will be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department will give written notice to the applicant.

(2) The department will hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant will be placed on a statewide priority waiting list. The department will assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion will be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4)*"b"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion will be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list will be based on the total number of criteria in subparagraph 83.61(4)*"b"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria will be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant will be placed higher on the waiting list.

(6) Applicants will remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment will determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons will be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department will give written notice to the person within five working days.

(2) The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

d. The state reserves payment slots each waiver year (July 1 to June 30) for use by children who must reside outside the family home in a residential-based supported community living licensed residential care facility. The state also reserves payment slots each waiver year (July 1 to June 30) for use by members living in an ICF/ID, nursing facility, or out-of-state placement, or transitioning from the Money Follows the Person Grant, who choose to access services in the intellectual disability waiver program and leave the ICF/ID, nursing facility, or out-of-state placement to live in the community.

(1) Applicants who currently reside in an ICF/ID or nursing facility and have resided in that setting for four or more months may request a reserved capacity slot through the intellectual disability waiver.

(2) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots will have the person's name maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on the person's order on the waiting list.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed.

83.62(2) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program will be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision will be made as soon as possible.

b. Decisions will be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant will be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker will have the member or legal representative indicate the member's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved will not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a member of group foster care services or is an inpatient in a medical institution will not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

83.62(3) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

d. Eligibility continues until the member fails to meet eligibility criteria listed in rule 441—83.61(249A). Members who are inpatients in a medical institution for 120 consecutive days will receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Members will be reviewed for eligibility under other Medicaid coverage groups. The member or legal representative will participate in the review and receive formal notification of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the individual that is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services will be completed at least once every 12 months. In years in which an interRAI assessment is not completed, the core standardized assessment contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous interRAI or other full assessment. An information assessment tool will be completed annually for children under the age of six. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The department or the member's MCO will be responsible for annual redetermination of the level of care.

83.64(2) The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.65 Reserved.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.67(249A) Service plan. A service plan will be prepared for each HCBS intellectual disability waiver member.

83.67(1) *Development.* The service plan will be developed by the interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager or service worker, service providers, and others directly involved.

83.67(2) *Retention.* The service plan will be stored by the case manager for a minimum of three years.

83.67(3) *Interdisciplinary team meeting.* The interdisciplinary team meeting will be conducted before the current service plan expires.

83.67(4) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a member at the time of waiver program enrollment.

b. For supported community living:

(1) The member's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the member.

(3) The number of other waiver members who will live with the member in the living unit.

c. An identification and justification of any restriction of the member's rights, including but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The name of the service provider responsible for providing each service.

e. The service funding source.

f. The amount of the service to be received by the member.

g. Whether the member has elected the consumer choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

h. A plan for emergencies and identification of the supports available to the member in an emergency.

i. For members receiving daily supported community living, day habilitation, or adult day care, the assignment to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the interRAI-ID and ChYMH-DD scores.

83.67(5) *Documentation.* The Medicaid case manager will ensure that the member's case file contains the member's service plan and documentation supporting the diagnosis of intellectual disability.

83.67(6) *Approval of plan.* The plan will be approved through the institutional and waiver authorization and narrative system (IoWANS). Services shall be entered into IoWANS based on the service plan.

a. Services must be authorized and entered into IoWANS before the plan implementation date.

b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within ten days, the department has final authority regarding the services and service cost.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3)*"a"* or *"b"* apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"d," "g,"* or *"h"* apply.

b. Needed services are not available or received from qualifying providers.

c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program member has not occurred.

g. The member receives services from other Medicaid waiver programs.

h. The member or legal representative through the interdisciplinary process requests termination from the services.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.69(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal shall be given in accordance with 441—Chapter 2506.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.70(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. More information can be found in 265—Chapter 24.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.71 to **83.80** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

"Assessment" means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires and goals.

"Basic individual respite" means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" or *"BI"* means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, that temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.
Malignant neoplasms of brain, frontal lobe.
Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.

Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the member's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Direct service" means services involving face-to-face assistance to a member such as transporting a member or providing therapy.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in DSM-5 or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

"Medical assessment" means a visual and physical inspection of the member, noting deviations from the norm, and a statement of the member's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"Medical intervention" means member care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the member's care and treatment to meet the physical and mental needs of the member in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the member's plan of care.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Organization" means the entity being certified.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a member that will allow the member to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician associate; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

"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.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.

● Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payment" means payment from an individual, institution, corporation, or public or private provider that is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a member of medical assistance.

"Usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a member must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be at least one month of age.

d. Be a U.S. citizen and Iowa resident.

e. Reserved.

f. Be determined by the department as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed information submission tool for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. The information submission tool, the interRAI - PEDS-HC, and the interRAI - HC and the MPAI are available on request from the member's MCO or the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

g. Be assessed by the department as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the member must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the member is eligible must be maximized before the member accesses interim medical monitoring and treatment.);

(3) Residing in the member's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician associate.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in 441—subrule 78.43(15), not be living in a residential care facility.

n. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.

o. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

p. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as amended to July 1, 2026; or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended to July 1, 2026.

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) *Need for services.*

a. The applicant will have a service plan approved by the department that is developed by the Medicaid case manager for this waiver. This must be completed before services provision and annually thereafter. The case manager will establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the department.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state plan services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the department's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training will be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent

in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The member shall access, if a child, all other services for which the person is eligible and that are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

83.82(3) *Securing a state payment slot.*

a. The department field office will enter all waiver applications into the institutional and waiver authorization and narrative system (IoWANS) to determine whether a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed services application or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department will enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the waiting list on the basis of the date a completed health services application is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid will be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants will be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots will have their applications rejected but their names will be maintained on the waiting list. As slots become available, persons will be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an ICF/ID, a skilled nursing facility, or an ICF and have resided in that setting for four or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots will have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department will reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state. Applicants may request an emergency need reserved capacity slot by submitting the completed home- and community-based services (HCBS) brain injury waiver emergency need assessment to the department.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion will be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(3)*"e"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion will be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list will be based on the total number of criteria in subparagraph 83.82(3)*"e"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list will be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer will be placed higher on the waiting list. If the application date is the same, the older applicant will be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria will remain on the waiting list, based on the date of application. If the application date is the same, the older applicant will be placed higher on the waiting list.

(6) Applicants will remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the department and request that a new emergency needs assessment be completed. The outcome of the assessment will determine placement on the waiting list as directed in this subrule.

f. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department will give written notice to the person within five working days.

(2) The department will hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot will revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the member to have all medically necessary service needs met within the scope of this waiver will be initiated on behalf of the member and with the member's consent or with the consent of the member's legal representative by the discharge planner of the medical facility where the member resides at the time of application or the case manager. The discharge planner or case manager will provide to the department all appropriate information needed regarding all the medically necessary service needs of the member. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the department will inform the discharge planner or case manager on behalf of the member or the member's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the member's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver will be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions will be mailed or given to the member or the member's legal representative on the date when each eligibility determination is completed.

c. An applicant will be given the choice between waiver services and institutional care. The applicant or legal representative will sign the applicable information submission tool listed in paragraph 83.82(1)*"f,"* indicating that the applicant has elected home- and community-based services. This will be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, will contact the member's MCO or the designated case manager to initiate development of the member's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager will establish an HCBS BI waiver interdisciplinary team for each member and, with the team, identify the member's "need for service" based on the member's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

c. Eligibility for the waiver continues until the member fails to meet eligibility criteria listed in rule 441—83.82(249A). Members who return to inpatient status in a medical institution for more than 120 consecutive days will be reviewed by the department to determine additional inpatient needs for possible termination from the brain injury waiver. The member will be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.17(249A). The member will be notified of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver member meets the level of care criteria in a medical institution as established by the peer review organization will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for prior institutionalizations will be applied to the waiver application.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.84(249A) Client participation. Members who are financially eligible under 441—paragraph 75.6(4)*"b"* (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation will be computed by deducting an amount for the maintenance needs of the member that is 300 percent of the maximum SSI grant for an individual from the member's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid will make no payments for the waiver service. However, Medicaid will make payments to other medical providers.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver will be completed at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination will contain the components listed in rule 441—83.82(249A).

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, member-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.87(249A) Service plan. A service plan will be prepared and utilized for each HCBS BI waiver member. The service plan will be developed by an interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager, providers, and others directly involved. The service plan will be stored by the case manager for a minimum of three years. The service plan staffing will be conducted before the current service plan expires.

83.87(1) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a member at the time of waiver program enrollment.

b. For supported community living:

(1) The member's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the member.

(3) The number of other waiver members who will live with the member in the living unit.

c. An identification and justification of any restriction of a member's rights, including but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The names of all providers responsible for providing all services.

e. All service funding sources.

f. The amount of the service to be received by the member.

g. Whether the member has elected the member choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

h. A plan for emergencies and identification of the supports available to the member in an emergency.

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for

members aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department. The Medicaid case manager will attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The department will assess the member annually and certify the member's need for long-term care services. The department will be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1)*"f"* and other supporting documentation as relevant.

a. The department or the member's MCO will be responsible for annual redetermination of the level of care.

b. The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) *Service file.* The Medicaid case manager must ensure that the member service file contains the member's service plan.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.88(249A) Adverse service actions.

83.88(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. The member is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the member's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the member that will meet the member's needs.

g. The member receives services from other Medicaid waiver providers.

h. The member or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3)*"a"* or *"b"* apply.

83.88(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"d," "g,"* or *"h"* apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury waiver service is not identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service member has not occurred.

g. The member receives services from other Medicaid providers.

h. The member or legal representative through the interdisciplinary process requests termination from the services.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.89(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 2506.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.90 to **83.100** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a physical disability aged 18 years to 64 years.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

"Assessment" means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires and goals.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Client participation" means the amount of the member's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"Guardian" means a guardian appointed in probate court for an adult.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in DSM-5 or has a related condition as defined in 42 CFR 435.1009 as amended to July 1, 2026, and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital that has been approved as a Medicaid vendor.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Physical disability" means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes

the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payment" means payment from an individual, institution, corporation, or public or private provider that is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a member of medical assistance.

"Waiver year" means a 12-month period commencing on April 1 of each year.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a member must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a physical disability.

b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act as amended to July 1, 2026, or the disability guidelines for the Medicaid employed people with disabilities coverage group.

c. Be ineligible for the HCBS intellectual disability waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the member.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Reserved.

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - PEDS-HC and the interRAI - HC are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

(1) Initial decisions on level of care will be made for the department by the department within two working days of receipt of medical information. Iowa Medicaid determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.10(1) and 79.10(2).

(2) Adverse decisions may be appealed to the department pursuant to 441—Chapter 2506.

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) *Need for services.*

a. The applicant will have a service plan that is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager will identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in paragraph 83.102(1)*"h,"* as well as the availability and appropriateness of services.

(2) The service worker will have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, will not exceed $793.20 per month.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state will be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots will be available on a first-come, first-served basis.

83.102(4) *Securing a slot.*

a. The department field office will enter all waiver applications into the institutional and waiver authorization and narrative system (IoWANS) to determine whether a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the department field office will make the entry by the end of the fifth working day after receipt of a completed application for health services and help paying costs or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the department field office will make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department will enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid will be entered on the basis of the date a completed health services application is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid will be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants will be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie will be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots will have their applications rejected but their names will be maintained on the waiting list. As slots become available, persons will be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(5) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list will be sent to the person by the department.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver will be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner will contact the member's MCO or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h."*

(2) After completing the determination of the level of care needed by the applicant, the department will inform the income maintenance worker and the discharge planner of the decision.

b. Applications for this waiver will be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's MCO or the designated case manager will arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and submit it to the department.

(2) After completing the determination of the level of care needed by the applicant, the department will inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver will be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions will be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant will be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care will sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care will cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The member may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—paragraph 75.6(4)*"b"* and, for married persons, in rule 441—75.82(249A) have been satisfied.

c. Eligibility for the waiver continues until the member fails to meet eligibility criteria listed in subrule 83.102(1). Members who return to inpatient status in a medical institution for more than 120 consecutive days will be reviewed by Iowa Medicaid to determine additional inpatient needs for possible termination from the physical disability waiver. The member will be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.17(249A). The member will be notified of that decision through a notice of decision.

If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.82(249A), the date on which the waiver member meets the institutional level of care requirement as determined by the department or an appeal decision will be used as the date of entry to the medical institution. Only one attribution of resources will be completed per person. Attributions completed for a prior institutionalization will be applied to the waiver application.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.104(249A) Client participation. Members who are financially eligible under 441—paragraph 75.6(4)*"b"* (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation will be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum supplemental security income (SSI)

grant for an individual from the member's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid will make no payments for the waiver service. However, Medicaid will make payments to other medical providers.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver will be completed at least once every 12 months. A redetermination of continuing eligibility factors will be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination will contain the components listed in rule 441—83.102(249A).

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are member-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.107(249A) Individual service plan. An individualized service plan will be prepared and used for each HCBS physical disability waiver member. The service plan will be developed and approved by the member, the member's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) *Information in plan.* The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a member at the time of waiver program enrollment.

b. The name of all providers responsible for providing all services.

c. All service funding sources.

d. The amount of the service to be received by the member.

e. Whether the member has elected the member choices option and, if so:

(1) The independent support broker selected by the member; and

(2) The financial management service selected by the member.

f. A plan for emergencies and identification of the supports available to the member in an emergency.

83.107(2) *Annual assessment.* The department or an MCO will review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1)*"h"* and the appeal process in rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and other supporting documentation as relevant.

a. The department or the member's MCO will be responsible for annual redetermination of the level of care.

b. The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.108(249A) Adverse service actions.

83.108(1) *Denial.* An application for services will be denied when it is determined by the department that:

a. All of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the member's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the member that will meet the member's needs.

g. The member receives services from other Medicaid waiver providers.

h. The member or legal representative requests termination from the services.

83.108(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—paragraph 130.5(3)*"a"* or *"b"* apply.

83.108(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"d," "g,"* or *"h"* apply.

b. Needed services are not available or received from qualifying providers.

c. The physical disability waiver service is not identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the member for the physical disability waiver service has not occurred.

g. The member receives services from other Medicaid providers.

h. The member or legal representative requests termination from the services.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.109(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 2506.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.110 to **83.120** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

"Assessment" means the review of the member's current functioning in regard to the member's situation, needs, abilities, desires, and goals.

"Case manager" means the person designated to provide Medicaid targeted case management services for the member.

"CMS" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"Deeming" means considering parental or spousal income or resources as income or resources of a member in determining eligibility for a member according to Supplemental Security Income program guidelines.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association as amended to July 1, 2026.

"Guardian" means a parent of a member or a legal guardian appointed by the court.

"HCBS" means home- and community-based services provided under a Medicaid waiver.

"IME QIO" means the entity contracted with the department that determines the level of care for members initially applying for or continuing to receive children's mental health waiver services.

"Interdisciplinary team" means the member, the member's family, and persons of varied professional and nonprofessional backgrounds with knowledge of the member's needs, as designated by the member and the member's family, who meet to develop a service plan based on the individualized needs of the member.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

"Medical institution" means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

"Member" means an individual up to the age of 18 who is included in a Medicaid coverage group listed in rule 441—75.1(249A) and is a recipient of children's mental health waiver services.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field, including but not limited to psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Psychiatric medical institution for children level of care" means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.10(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by DSM-5 and (2) has resulted in a functional impairment that substantially interferes with or limits a member's role or functioning in family, school, or community activities. "Serious emotional disturbance" does not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in DSM-5 as "other conditions that may be a focus of clinical attention" unless these conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team that includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Targeted case management" means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for members eligible for the children's mental health waiver.

"Waiver year" for the children's mental health waiver means a 12-month period commencing on July 1 of each year.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.122(249A) Eligibility. To be eligible for children's mental health waiver services, a member must meet all of the following requirements:

83.122(1) *Age.* The member must be under 18 years of age.

83.122(2) *Diagnosis.* The member must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The department or an MCO will certify the applicant's level of care annually based on information submitted on the interRAI Early Years for children aged 3 and under or on the interRAI - child and youth mental health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - adolescent supplement will also be completed in addition to the interRAI - ChYMH. The interRAI Early Years, interRAI - ChYMH and interRAI - adolescent supplement are available on request from the department. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or MCO.

83.122(4) *Financial eligibility.* The member must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under a supplemental security income (SSI), SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) *Choice of program.* The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on the assessment.

83.122(6) *Need for service.* The member must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.127(249A).

a. The member must be a recipient of case management or be identified to receive case management immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, cannot exceed $2,274.96 per month.

c. At a minimum, each member must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A member may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A member may be enrolled in only one HCBS waiver program at a time.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) through 441—76.6(249A) will be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of members specified in the approved waiver, the member's application will be rejected and the member's name shall be placed on a waiting list.

a. The local office will determine whether a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed application for health services or help paying costs from a member who is not currently a Medicaid member; or

(2) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office will enter the application into institutional and waiver authorization and narrative system (IoWANS) to begin the waiver approval process.

(1) The department will hold the payment slot for the member as long as reasonable efforts are being made to arrange services and the member has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot will revert for use by the next member on the waiting list, if applicable. The member must reapply for a new slot.

c. If no payment slot is available, the department will enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed application for health services or help paying costs is received by the department;

(2) The names of Medicaid members will be added to the waiting list on the date as specified in paragraph 83.123(1)*"a."*

(3) In the event that more than one application is received at one time, the names of members will be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Members whose names are on the waiting list will be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved members on the program is maintained.

(1) Once a payment slot is assigned, the department will give written notice to the member within five working days.

(2) The department will hold the payment slot for 30 days for the member to file a new application.

(3) If an application has not been filed within 30 days, the slot will revert for use by the next member on the waiting list, if applicable. The member originally assigned the slot must reapply for a new slot.

e. The state reserves payment slots each waiver year (October 1 to September 30) for use by members living in a state of Iowa mental health institute (MHI), a psychiatric residential treatment facility (PRTF), or an out-of-state facility placement who choose to access services in the children's mental health waiver program and leave the MHI, PRTF, or out-of-state placement to live within their family home. For the purpose of reserved capacity within the children's mental health waiver program, an MHI is defined in Iowa Code section 226.1 and a PRTF is defined in 42 CFR 483.352 as amended to July 1, 2026.

(1) Applicants who currently reside in an MHI, PRTF, or out-of-state placement and have resided in that setting for four or more months may request a reserved capacity slot through the children's mental health waiver program.

(2) Applicants will be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(3) In the event that more than one request for a reserved capacity slot is received at one time, applicants will be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(4) Persons who do not fall within the available reserved capacity slots will have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons will be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

83.123(2) *Approval of waiver eligibility.*

a. Time limit. Applications for the HCBS children's mental health waiver program will be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal SSI benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the member or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application will be denied.

b. *Notice of decisions.* The department will mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) *Effective date of eligibility.* The effective date of a member's eligibility for children's mental health waiver services will be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

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441—83.124(249A) Financial participation. A member must contribute to the cost of children's mental health waiver services to the extent of the member's total income less 300 percent of the maximum monthly payment for one person under the federal SSI program.

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441—83.125(249A) Redetermination. The department will redetermine a member's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the member's situation or condition.

83.125(1) *Eligibility review.*

a. Every 12 months, the department will review a member's eligibility in accordance with procedures in rule 441—76.17(249A). The review will verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The department or an MCO will review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process in rule 441—83.129(249A), based on the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

c. The department or the member's MCO will be responsible for annual redetermination of the level of care.

d. The MCO must submit documentation to Iowa Medicaid for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) *Continuation of eligibility.* A member's waiver eligibility will continue until one of the following conditions occurs.

a. The member fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The member is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the member has spent 120 consecutive days in a medical institution, the local office will terminate the member's waiver eligibility and review the member for eligibility under other Medicaid coverage groups. The local office will notify the member and the member's parents or legal guardian through a notice of decision.

(2) If the member returns home after 120 consecutive days, the member must reapply for children's mental health waiver services, and Iowa Medicaid must redetermine the member's level of care.

c. The member does not reside at the member's natural home for a period of 60 consecutive days. After the member has resided outside the home for 60 consecutive days, the local office will terminate the member's waiver eligibility and review the member for eligibility under other Medicaid coverage groups. The local office will notify the member and the member's parents or legal guardian through a notice of decision.

83.125(3) *Payment slot.* When a member loses waiver eligibility, the member's assigned payment slot will revert for use to the next member on the waiting list.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver will be provided as set forth in rule 441—78.52(249A) and will include:

1. Environmental modifications, adaptive devices and therapeutic resources;

2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

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441—83.127(249A) Service plan. The member's case manager will prepare an individualized service plan for each member that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan will be developed through an interdisciplinary team process.

83.127(2) The service plan will be developed annually or when there is significant change in the member's situation or condition.

83.127(3) The service plan will be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan will specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan will identify and justify any restriction of the member's rights.

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services will be denied when the department determines that:

a. The member is not eligible for or in need of waiver services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the limit on aggregate monthly costs established in paragraph 83.122(6)*"b"* or are not met by the services provided.

83.128(2) *Termination.* A member's participation in the children's mental health waiver program may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the children's mental health waiver services for the member exceed the aggregate monthly costs established in paragraph 83.122(6)*"b."*

c. The member receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.

d. The physical or mental condition of the member requires more care than can be provided in the member's own home, as determined by the member's case manager.

e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services will apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

[**ARC 0318D**, IAB 5/27/26, effective 7/1/26]

441—83.129(249A) Appeal rights. Notice of adverse action will be given in accordance with rule 441—16.2(17A). The right to appeal will be given in accordance with 441—Chapter 2506.

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CHAPTER 84
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

[Prior to 7/1/83, Social Services [770] Ch 84]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

441—84.1(249A) Definitions.

"Diagnosis" is the determination of the nature of physical or mental disease or abnormality.

"Interperiodic screen" means a screen that occurs between the times stated in the periodicity schedule in 441—subrule 78.18(3).

"Screening" is the use of quick, simple procedures to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of more definitive study. These services will be provided in accordance with reasonable standards of medical and dental practice.

[**ARC 9067C**, IAB 4/2/25, effective 6/1/25]

441—84.2(249A) Eligibility. All persons eligible for medical assistance under age 21 are eligible for early and periodic screening, diagnosis, and treatment.

[**ARC 9067C**, IAB 4/2/25, effective 6/1/25]

441—84.3(249A) Screening services. Screening services shall be provided in accordance with 42 CFR §441.56 as amended to August 1, 2024, and may be done by a screening center or other qualified providers. Other qualified providers are physicians, advanced registered nurse practitioners, rural health centers, federally qualified health centers, laboratories, clinics, and dentists.

[**ARC 9067C**, IAB 4/2/25, effective 6/1/25]

441—84.4(249A) Referral.

84.4(1) The availability of early and periodic screening will be discussed with the payee for any Medicaid-eligible child under the age of 21 at the time of application and periodically thereafter in compliance with federal regulations at Title 42, Part 441, Subpart B, as amended to March 29, 2022.

84.4(2) Screening will be offered to each eligible individual according to the periodicity schedule in 441—subrule 78.18(3) when screening has been accepted, or on at least an annual basis when screening has been rejected. Interperiodic screens may be furnished when medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment.

[**ARC 9067C**, IAB 4/2/25, effective 6/1/25]

441—84.5(249A) Follow up. Follow-up services will be provided when a referral for screening was accepted, but 60 days have elapsed and no screening examination has been performed, and when a screening examination discloses a possible abnormal condition and a referral was made for further diagnosis or treatment and such diagnosis or treatment has not been received within a period of 60 days from the date of the screening examination.

[**ARC 9067C**, IAB 4/2/25, effective 6/1/25]

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CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—85.1(249A) Acute care in psychiatric hospitals. These rules do not apply to general hospitals with psychiatric units.

85.1(1) *Psychiatric hospitals serving persons aged 21 and older.* A psychiatric hospital serving persons aged 21 and older shall meet the federal criteria for an institution for mental disease and shall be licensed pursuant to rule 481—51.23(135B). An out-of-state facility shall be licensed as a psychiatric hospital, shall meet the federal criteria for an institution for mental disease, and shall be certified to participate in the Medicare program. An institution is an institution for mental disease only if its overall character is that of a facility established and maintained primarily for the care and treatment of persons with mental diseases. The following guidelines are used by the department in evaluating the overall character of a facility. These guidelines are all useful in identifying institutions for mental disease; however, no single guideline is necessarily determinative in any given case.

a. The facility:

(1) Is licensed as a psychiatric facility for the care and treatment of persons with mental diseases.

(2) Advertises or holds itself out as a facility for the care and treatment of persons with mental diseases.

(3) Is accredited as a psychiatric facility by the Joint Commission or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections, appeals, and licensing.

(4) Specializes in providing psychiatric or psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric or psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

(5) Is under the jurisdiction of the department.

b. More than 50 percent of all the patients in the facility have mental diseases that require inpatient treatment according to the patient's medical records.

c. A large proportion of the patients in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders.

d. Independent review teams report a preponderance of mental illness in the diagnoses of the patients in the facility.

e. The average patient age is significantly lower than that of a typical nursing home.

f. Part or all of the facility consists of locked wards.

85.1(2) *Psychiatric hospitals serving persons under the age of 21.* A psychiatric hospital serving persons under the age of 21 shall be licensed pursuant to rule 481—51.23(135B) or shall be licensed in another state as a hospital; shall be accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Children and Family Services, or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections, appeals, and licensing; and shall meet federal service requirements.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.2(249A) Out-of-state placement. Placement in an out-of-state psychiatric hospital for acute care requires prior department approval and must be approved only if special services are not available in Iowa.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.3(249A) Eligibility of persons under the age of 21.

85.3(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric hospital, the person shall be under 21 years of age. When treatment in the hospital is provided immediately preceding

the person's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.3(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status the eligible person is entitled to the full scope of Medicaid benefits.

85.3(3) *Certification of need for care.* For persons eligible for Medicaid prior to admission, the need for care shall be certified in accordance with 42 CFR 441.152 (as amended to August 1, 2024). A form prescribed by the department may be used to document these criteria.

a. For persons eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department. A physician's assistant or advanced registered nurse practitioner may also serve as a member of the plan of care team.

The evaluation must be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.3(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by a psychiatric facility, persons under the age of 21 must be eligible under one of the coverage groups listed in 441—Chapter 75.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.4(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by an institution for mental disease, persons must be aged 65 or over and be eligible under one of the coverage groups listed in 441—Chapter 75.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.5(249A) Client participation. The resident is not liable to pay client participation toward the cost of care, and no client participation amount shall be deducted from the state payment to the hospital.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.6(249A) Responsibilities of hospitals.

85.6(1) *Medical record requirements.* The medical records maintained by the psychiatric hospital shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the hospital.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within 60 hours of admission.
(2) Include a medical history.
(3) Contain a record of mental status.
(4) Note the onset of illness and the circumstances leading to admission.
(5) Describe attitudes and behavior.
(6) Estimate intellectual functioning, memory functioning, and orientation.
(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires acute psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care general hospital, or enters the facility after 30 consecutive days of visitation.

85.6(2) *Fiscal records.*

a. A case activity report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized in a general hospital, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.6(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment in accordance with 42 CFR 441.154 (as amended to August 1, 2024).

b. Individual plan of care. An individual plan of care shall be developed and implemented for each recipient in accordance with 42 CFR 441.155 (as amended to August 1, 2024).

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility in accordance with 42 CFR 441.156 (as amended to August 1, 2024). The team may also include a physician's assistant or an advanced registered nurse practitioner.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.7(249A) Psychiatric hospital reimbursement.

85.7(1) *Reimbursement formula.* Acute care in psychiatric hospitals will be reimbursed on a per diem rate based on Medicare principles.

a. The reimbursement principles follow and comply with the retrospective Principles of Medicare reimbursement found in Title 18 of the Social Security Act (as amended to August 1, 2024).

b. Allowable costs are those defined as allowable in 42 CFR, Subpart A, Sections 413.5 and 413.9 (as amended to August 1, 2024), and 42 CFR 447.250 (as amended to August 1, 2024). Only those costs are considered in calculating the Medicaid inpatient reimbursement.

c. Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost and to adhere to all Medicare cost principles in the calculation of the facility rates.

d. Payment for inpatient hospital care for recipients for whom the PRO has determined that the level of care that is medically necessary is only that of skilled care or nursing care will be made at a rate equal to the statewide average Medicaid skilled nursing facility rate or the average state nursing facility rate. Periodic PRO determinations of the need for continuing care are also required.

e. Each participating Medicaid provider shall file a CMS 2552 Medicare Cost Report or a substitute accepted by the Centers for Medicare and Medicaid Services (CMS). In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the department within 150 days after the close of the hospital's fiscal year.

f. Compensation for a disproportionate share of indigent patients is determined as described in 441—subrule 79.1(5).

g. Medicaid reimbursement will be reduced by any payments from a third party toward the cost of a patient's care.

85.7(2) *Medical necessity.* The medical necessity of admission and continued stay will be determined by the PRO. Payment shall not be made for admissions that are determined not to be medically necessary nor will payment be approved for stays beyond the time at which inpatient specialized hospital care at the acute level has been determined not to be medically necessary.

85.7(3) *Reserve bed day payment.* No reserve bed day payments are made to acute care psychiatric hospitals.

85.7(4) *Outpatient services.* No coverage is available for outpatient psychiatric hospital services.

These rules are intended to implement Iowa Code section 249A.4.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64.

85.8(1) *Facility.* Acute care in a psychiatric hospital is covered for persons aged 21 through 64 only at the state mental health institutes at Cherokee and Independence.

85.8(2) *Basis of eligibility.* To be eligible for payment for the cost of care provided by one of the covered facilities, a person aged 21 through 64 must be eligible for one of the coverage groups listed in 441—Chapter 75.

85.8(3) *Period of eligibility.* A person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of discharge.

85.8(4) *Extent of eligibility.* While on inpatient status, a person eligible under a coverage group listed in rule 441—75.1(249A) is entitled to the full scope of Medicaid benefits.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.9(249A) Psychiatric medical institutions for children—conditions for participation. Psychiatric medical institutions for children will be issued a license by the department of inspections, appeals, and licensing under Iowa Code chapter 135H and will hold either a license from the department under Iowa Code section 237.3(2)*"a"*(3), or, for facilities that provide substance use disorder treatment, a license from the department under Iowa Code section 125.13.

This rule is intended to implement Iowa Code sections 135H.4 and 249A.4.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.10(249A) Eligibility of persons under the age of 21.

85.10(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric medical institution for children, the person shall be under 21 years of age. When treatment in the facility is provided immediately preceding the individual's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.10(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status, the eligible individual is entitled to the full scope of Medicaid benefits.

85.10(3) *Certification for need for care.* For persons eligible for Medicaid prior to admission, the need for care shall be certified in accordance with 42 CFR 441.152 (as amended to August 1, 2024). A form prescribed by the department may be used to document these criteria.

a. For persons determined eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department. A physician's assistant or advanced registered nurse practitioner may also serve as a member of the plan of care team.

The evaluation will be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.10(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by psychiatric medical institutions, persons under the age of 21 shall be eligible under one of the coverage groups listed in 441—Chapter 75, except medically needy.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.11(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to 441—Chapter 75.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.12(249A) Responsibilities of facilities.

85.12(1) *Medical record requirements.* The medical records maintained by psychiatric medical institutions for children shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the facility.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is admitted.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within seven days of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's stay at the facility and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a PRO determination that the person requires psychiatric medical institution level of care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.12(2) *Fiscal records.*

a. A Case Activity Report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.12(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment in accordance with 42 CFR 441.154 (as amended to August 1, 2024).

b. Individual plan of care. An individual plan of care shall be developed and implemented for each recipient in accordance with 42 CFR 441.155 (as amended to August 1, 2024).

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility in accordance with 42 CFR 441.156 (as amended to August 1, 2024). The team may also include a physician's assistant or an advanced registered nurse practitioner.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.13(249A) Outpatient day treatment for persons aged 20 or under. Payment to a psychiatric medical institution for children will be approved for day treatment services for persons aged 20 or under if the psychiatric medical institution for children is certified by the department of inspections, appeals, and licensing for day treatment services and the services are provided on the licensed premises of the psychiatric medical institution for children.

EXCEPTION: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan. All conditions for the day treatment program for persons aged 20 or under as outlined in 441—subrule 78.16(7) for community mental health centers shall apply to psychiatric medical institutions for children.

These rules are intended to implement Iowa Code section 249A.4.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.14(249A) Conditions of participation. A nursing facility for persons with mental illness shall be licensed pursuant to 481—Chapter 65, or, if the facility is a distinct part of a hospital, pursuant to rule 481—51.24(135B). A distinct part of a general hospital may be considered a psychiatric institution. In

addition, the facility shall be certified to participate in the Iowa Medicaid program as a nursing facility pursuant to 441—Chapter 81 and shall have 16 beds or more. The facility shall also meet the criteria set forth in subrule 85.1(1).
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.15(249A) Out-of-state placement. Placement in out-of-state nursing facilities for persons with mental illness is not payable.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.16(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by nursing facilities for persons with mental illness, persons must be aged 65 or over and be eligible under one of the coverage groups listed in 441—Chapter 75, except for medically needy.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.17(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.18(249A) Responsibilities of nursing facility.

85.18(1) *Medical record requirements.* The facility shall obtain a PRO determination that a person requires psychiatric care when the person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.18(2) *Fiscal records.*

a. A Case Activity Report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.19(249A) Policies governing reimbursement. Cost reporting, reserve bed day payment, and reimbursement shall be the same for nursing facilities for persons with mental illness as for nursing facilities as set forth in 441—Chapter 81.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.20(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental illness who has countable income for purposes of rule 441—75.16(249A) of less than $55 per month will receive a state-funded payment from the department for the difference between that countable income and $55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25; **ARC 9859C**, IAB 12/24/25, effective 2/1/26]

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CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWKI) PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—86.1(514I) Definitions.

"Administrative error" means an action of the department that results in incorrect payment of benefits, including premiums paid to a health or dental plan, due to one or more of the following circumstances:

1. Misfiled or lost form or document.
2. Error in typing or copying.
3. Computer input error.
4. Mathematical error.
5. Failure to determine eligibility correctly when all essential information was available to the department.
6. Failure to request essential verification necessary to make an accurate eligibility determination.
7. Failure to make timely revision in eligibility following a change in policy requiring application of the policy change as of a specific date.
8. Failure to issue timely notice to cancel benefits that results in benefits continuing in error.

"Applicant" means anyone in the household, including all adults and children under the age of 19 who are counted in the hawki family size according to the modified adjusted gross income methodology and who are listed on the application or renewal form.

"Capitation rate" means the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

"Client error" means any action or inaction of the enrollee or the enrollee's representative that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because at least one of the following occurred:

1. The enrollee or the enrollee's representative failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. The enrollee or the enrollee's representative failed to timely report a change as defined in rule 441—86.10(514I).

"Contract" means the contract between the department and the participating health or dental plan for the provision of medical or dental services to hawki enrollees for whom the participating health or dental plans assume risk.

"Cost sharing" means the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act, as amended to August 1, 2024, and Iowa Code section 514I.10.

"Countable income" means earned and unearned income of the family according to the modified adjusted gross income methodology.

"Covered services" means all or a part of those medical and dental services set forth in rule 441—86.14(514I).

"Dentist" means a person who is licensed to practice dentistry.

"Eligible child" means an individual who meets the criteria for participation in the hawki program as set forth in rule 441—86.2(514I).

"Emergency dental condition" means an oral condition that occurs suddenly and creates an urgent need for professional consultation or treatment. Emergency conditions may include hemorrhage, infection, pain, broken teeth, knocked-out teeth, or other trauma.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,

2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

"Emergency services" means, with respect to an individual enrolled with a plan, covered inpatient and outpatient services that are furnished by a provider qualified to furnish these services and that are needed to evaluate and stabilize an emergency medical or dental condition.

"Enrollee" means a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

"Enrollment broker" means the entity the department uses to enroll eligible children with a managed care organization. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law.

"Family" means anyone in the household, including all adults and children under the age of 19 who are counted in the hawki family size according to the modified adjusted gross income methodology.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

"Good cause" means the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee's control.
4. There was a failure to receive the department's request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

"Hawki program" or *"program"* means the healthy and well kids in Iowa program implemented in this chapter to provide health and dental care coverage to eligible children.

"Health insurance coverage" means health insurance coverage as defined in 45 CFR Section 144.103 as amended to August 1, 2024.

"Health Insurance Marketplace" or *"Exchange"* means the entity authorized under 42 U.S.C. Section 18031(d)(4)(F) (as amended to August 1, 2024) to evaluate and determine eligibility of applicants for Medicaid, the Children's Health Insurance Program (CHIP), and other health programs.

"Initial application" means the first program application or a subsequent application that is not a renewal.

"Institution for mental diseases" means the same as defined in 42 CFR Section 435.1010 as amended to August 1, 2024.

"Medical Assistance Advisory Council" or *"MAAC"* means the advisory body authorized by Iowa Code section 249A.4B.

"Modified adjusted gross income" means the methodology prescribed in 42 U.S.C. Section 1396a(e)(14) and 42 CFR 435.603 as amended to August 1, 2024.

"Participating dental plan" means any entity licensed by the division of insurance of the department of insurance and financial services to provide dental insurance in Iowa that has contracted with the department to provide dental insurance coverage to eligible children under this chapter.

"Participating health plan" or *"PHP"* means any entity licensed by the division of insurance of the department of insurance and financial services to provide health insurance in Iowa or an organized delivery system licensed by the director that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

"Passive enrollment process" means the process by which the department assigns a child to a participating health or dental plan and which seeks to preserve existing provider-enrollee relationships, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available health or dental plans.

"Physician" means the same as defined in Iowa Code section 135.1(4).

"Provider" means an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical or dental care or services to an enrollee pursuant to the hawki program.

"Public institution" means the same as defined in 42 CFR Section 435.1010 as amended to August 1, 2024.

"Renewal" means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

"Supplemental dental-only coverage" means dental care coverage provided to a child who meets the eligibility requirements for the hawki program except that the child is covered by health insurance through an individual or group health plan.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.2(514I) Eligibility factors. The decision with respect to eligibility will be based primarily on electronic data matches and information furnished by the applicant, the enrollee, or a person acting on behalf of the applicant or enrollee. A child must meet the following eligibility factors to participate in the hawki program:

86.2(1) *Age.* The child shall be under 19 years of age. Eligibility for the program ends the first day of the month following the month of the child's nineteenth birthday.

86.2(2) *Income.*

a. Countable income. In determining initial and ongoing eligibility for the hawki program, countable income shall not exceed 302 percent of the federal poverty level for a family of the same size. Countable income shall be determined using the modified adjusted gross income methodology.

b. Verification of income. Income shall be verified through electronic data matches when possible or otherwise verified using the best information available.

(1) Pay stubs, tip records, tax records and employers' statements are acceptable forms of verification of earned income.

(2) If self-employment income cannot be verified through electronic means, business records or income tax returns from the previous year can be used if they are representative of anticipated earnings. If business records or tax returns from the previous year are not representative of anticipated earnings, an average of the business records or tax returns from the previous two or three years may be used if that average is representative of anticipated earnings.

c. Changes in income. Once initial eligibility is established, changes in income during the 12-month enrollment period shall not affect the child's eligibility to participate in the hawki program. However, if income has decreased, the family may request a review of their income to establish whether they are required to continue paying a premium in accordance with rule 441—86.8(514I).

86.2(3) *Family size.* For purposes of establishing initial and ongoing eligibility under the hawki program, the family size shall be determined according to the modified adjusted gross income methodology.

86.2(4) *Uninsured status.* The child must be uninsured as outlined in 42 CFR 457 as amended to August 1, 2024.

86.2(5) *Ineligibility for Medicaid.* The child shall not be receiving Medicaid or eligible to receive Medicaid except when the child would be required to meet a spenddown under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

86.2(6) *Iowa residency.* Residency in Iowa is a condition of eligibility for the hawki program. Residency shall be established in accordance with rule 441—75.10(249A).

86.2(7) *Citizenship and immigration status.* To be eligible for the hawki program, the child shall be a citizen or lawfully admitted immigrant. The criteria established under 441—subrule 75.11(2) shall be followed when determining whether a lawfully admitted immigrant child is eligible to participate in the hawki program.

a. The citizenship or immigration status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

b. As a condition of eligibility for hawki:

(1) All applicants shall attest to their citizenship status by signing the application form, which contains a citizenship declaration.

(2) When a child under the age of 19 is not living independently, the child's parent or other responsible person with whom the child lives shall be responsible for attesting to the child's citizenship or immigration status and for providing any required proof of the status.

c. Except as provided in 441—paragraph 75.11(2)*"f,"* applicants or enrollees for whom an attestation of United States citizenship has been made pursuant to paragraph 86.2(7)*"b"* shall present satisfactory documentation of citizenship or nationality as defined in 441—paragraphs 75.11(2)*"d,""e," "g,""h,"* and *"i."*

d. An applicant or enrollee shall have a reasonable opportunity period to obtain and provide proof of citizenship and nationality in accordance with 441—paragraph 75.11(2)*"c."*

e. Failure to provide acceptable documentary evidence for a child shall not affect the eligibility of other children in the family for whom acceptable documentary evidence has been provided.

86.2(8) *Dependents of state of Iowa employees.* The child shall not be eligible for the hawki program if the child is eligible for health insurance coverage as a dependent of a state of Iowa employee unless the state contributes only a nominal amount toward the cost of dependent coverage. "Nominal amount" means $10 or less per month.

86.2(9) *Inmates of public institutions.* The child shall not be an inmate of a public institution as defined at 42 CFR Section 435.1010 as amended to August 1, 2024.

86.2(10) *Inmates of institutions for mental disease.* At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1010 as amended to August 1, 2024.

86.2(11) *Furnishing a social security number.* As a condition of eligibility and in accordance with rule 441—75.7(249A), a social security number or proof of application for the number if the number has not been issued or is not known must be furnished for a child for whom coverage under hawki is being requested or received.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.3(514I) Application process.

86.3(1) *Who may apply.* Each person wishing to do so shall have the opportunity to apply for the hawki program in accordance with rule 441—76.1(249A).

86.3(2) *Place of filing.* An application for the hawki program may be filed with the department through an internet website, by telephone, through other electronic means, or through an exchange, disproportionate share hospital, federally qualified health center, or other facility in which outstationing activities are provided.

86.3(3) *Right to withdraw application.* After an application has been filed, the applicant may withdraw the application at any time prior to the eligibility determination. Requests for voluntary withdrawal of the application will be documented, and the applicant will be sent a notice of decision confirming the request.

86.3(4) *Application not required.*

a. An application will not be required when a child becomes ineligible for Medicaid.

b. A new application will not be required when an eligible child is added to an existing hawki eligible group.

c. A new application will not be required when a child moves between supplemental dental-only coverage as specified in rule 441—86.20(514I) and full medical and dental coverage.

86.3(5) *Information and verification procedure.* The eligibility decision will be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee and verified through electronic data matches whenever possible.

a. The applicant, enrollee, or person acting on behalf of the applicant or enrollee will be notified in writing of additional information or verification that is required to establish eligibility. The notice may be provided personally, by U.S. mail, by email, or by facsimile.

b. Failure to supply the information or verification or refusal to authorize the department to secure the information will be a basis for rejection of the application or cancellation of coverage. If the requested information or authorization is received within 14 calendar days of the notice of decision on an application or within 14 calendar days of the effective date of cancellation for enrollees, the information or authorization will be acted upon as though it had been provided timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or enrollee shall have until the next business day to provide the information.

c. The applicant, enrollee, or person acting on behalf of the applicant or enrollee will have 10 working days to supply the information or verification requested. The due date may be extended for a reasonable period when the applicant, enrollee, or person acting on behalf of the applicant or enrollee is making every effort but is unable to secure the required information or verification from a third party.

86.3(6) *Time limit for decision.* Decisions regarding the applicant's eligibility to participate in the hawki program will be made within 45 working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed for reasons beyond the control of the department. Day one of the 45-day period starts the first working day following the date of receipt of a completed application and all necessary information and verification.

86.3(7) *Applicant cooperation.* An applicant must cooperate with the department in the application process, which may include providing verification or signing documents. Failure to cooperate with the application process shall serve as basis for a denial of the application.

86.3(8) *Waiting lists.* When the department has established that all the funds appropriated for this program are obligated, all subsequent applications for hawki coverage will be denied unless Medicaid eligibility exists.

a. The department will mail a notice of decision to the applicant that states:

(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or

(2) The applicant does not meet eligibility requirements, in which case the applicant will not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, it must be established that the child is not eligible for Medicaid.

c. Applicants will be placed on the waiting list on the basis of the date an identifiable application form specified in rule 441—76.1(249A) is received.

(1) In the event that more than one application is received on the same day, applicants will be placed on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list.

(2) Any subsequent ties will be determined by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, applicants will be selected from the waiting list based on the order in which their names appear on the list and will be notified of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the applicant's name will be deleted from the waiting list and the next applicant on the waiting list will be contacted.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.4(514I) Coordination with Medicaid.

86.4(1) *Hawki applicant eligible for Medicaid.* At the time of initial application, if it is determined the child is eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in the Medicaid program.

86.4(2) *Hawki enrollee eligible for Medicaid.* At the time of the annual review, if the child is determined eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in Medicaid effective the first day following the expiration of the 12-month hawki enrollment period.

86.4(3) *Medicaid member becomes ineligible.* If a child becomes ineligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spend down under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in the hawki program if otherwise eligible.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.5(514I) Effective date of coverage.

86.5(1) *Initial application.* Coverage for a child who is determined eligible for the hawki program on the basis of an initial application for either hawki or Medicaid will be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed. However, when the child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

86.5(2) *Referrals from Medicaid.*

a. Cancellation of Medicaid. Coverage for children who are determined eligible for the hawki program due to cancellation of Medicaid benefits will be effective the first day of the month after Medicaid eligibility is lost in order to ensure that there is no break in coverage.

b. If the child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology, the child may be covered under the hawki program for up to 12 months following the loss of Medicaid eligibility, regardless of the presence of other health insurance coverage.

86.5(3) *Annual renewals.* Coverage for children who are determined eligible for the hawki program on the basis of an annual renewal will be effective the first day of the month following the month in which the previous enrollment period ended.

86.5(4) *Children added to an existing hawki enrollment period.* Coverage for children who are determined eligible for the hawki program on the basis of a request from the family to add the child to an existing enrollment period will be effective the first day of the month following the month in which the request was made.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.6(514I) Selection of a plan. Upon the child's eligibility effective date, the child will be assigned to a health or dental plan using the department's passive enrollment process. The enrollee may change plans only at the time of the annual review unless the provisions of paragraph 86.6(1)*"a"* or subrule 86.6(2) apply.

86.6(1) *Period of enrollment.* Once enrolled in a health or dental plan, the child will remain enrolled in the health or dental plan for a period of 12 months.

a. Exceptions. A child may be enrolled in a plan for less than 12 months if:

(1) The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child will be enrolled in the health or dental plan from which the child was originally disenrolled.

(2) The child is added to an existing enrollment. When a family requests to add an eligible child, the child will be enrolled for the months remaining in the current enrollment period.

(3) A request to change plans is accepted in accordance with paragraph 86.6(1)*"b."*

b. Request to change plan. An enrollee may ask to change the health or dental plan either verbally or in writing to the enrollment broker:

(1) Within 90 days following the date of the enrollee's initial enrollment with the health or dental plan for any reason.

(2) At any time for cause. "Cause" as defined in 42 CFR 438.56(d)(2) as amended to August 1, 2024, includes but is not limited to:

1. The enrollee moves out of the plan's service area.
2. Because of moral or religious objections, the plan does not cover the services the enrollee seeks.
3. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

4. Other reasons including but not limited to poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

All approved changes shall be made prospectively and shall be effective no later than the first day of the second month beginning after the date on which the change request is received.

86.6(2) *Child moves from the service area.* The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child will be enrolled in a participating health or dental plan in the new location. The period of enrollment will be the number of months remaining in the original certification period.

86.6(3) *Change at annual review.* If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing to the enrollment broker. The child will remain enrolled in the current health or dental plan if the family does not notify the enrollment broker of a new health or dental plan choice by the end of the current 12-month enrollment period.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.7(514I) Cancellation. The child's eligibility for the hawki program shall be canceled before the end of the 12-month enrollment period for any of the following:

86.7(1) *Age.* The child shall be canceled from the hawki program as of the first day of the month following the month in which the child attained the age of 19.

86.7(2) *Iowa residence abandoned.* The child shall be canceled from the program as of the first day of the month following the month in which the child relocated to another state. Eligibility shall not be canceled when the child is temporarily absent from the state in accordance with the provisions of 441—subrule 75.10(2).

86.7(3) *Eligible for Medicaid.* The child shall be canceled from the program as of the first day of the month following the month in which Medicaid eligibility is obtained. If there are months during which the child is covered by both the Medicaid and hawki programs, the hawki program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(4) *Enrolled in other health insurance coverage.* The child shall be canceled from the program as of the first day of the month following the month in which the department is notified that the child has other health insurance coverage. If there are months during which the child is covered by both another insurance plan and the hawki program, the other insurance plan shall be the primary payor and hawki shall be the payor of last resort.

86.7(5) *Admission to a public institution.* The child shall be canceled from the program if the child is in a public institution at the time of the annual review.

86.7(6) *Admission to an institution for mental disease.* The child shall be canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(7) *Employment with the state of Iowa.* The child shall be canceled from the hawki program as of the first day of the month in which the child's parent became eligible to participate in a health or dental plan available to state of Iowa employees.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.8(514I) Premiums and copayments.

86.8(1) *Income considered.* The income considered in determining the premium amount will be the family's countable income using the modified adjusted gross income methodology.

86.8(2) *Premium amount.* Except as specified for supplemental dental-only coverage in subrule 86.20(3), premiums under the hawki program will be assessed as follows:

a. No premium is charged if:

(1) The eligible child is an American Indian or Alaska Native; or

(2) The family's countable income is less than 181 percent of the federal poverty level for a family of the same size.

b. If the family's countable income is equal to or exceeds 181 percent of the federal poverty level for a family of the same size but does not exceed 242 percent of the federal poverty level for a family of that size, the premium is $10 per child per month with a $20 monthly maximum per family.

c. If the family's countable income is equal to or exceeds 243 percent of the federal poverty level for a family of the same size, the premium is $20 per child per month with a $40 monthly maximum per family.

86.8(3) *Due date.*

a. Payment upon initial application. Upon approval of an initial application, the first month for which a premium is due is the third month following the month of decision. The due date of the first premium shall be the fifth day of the second month following the month of decision.

b. Payment upon renewal.

(1) Upon approval of a renewal, the first month for which a premium is due is the first month of the enrollment period. The premium for the first month of the enrollment period shall be due by the fifth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) When the premium is received, the department will notify the health and dental plans of the enrollment.

c. Subsequent payments. All subsequent premiums are due by the fifth day of each month for the next month's coverage. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. Holiday or weekend. When the premium due date falls on a holiday or weekend, the premium shall be due on the first business day following the due date.

86.8(4) *Method of premium payment.* Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the department.

86.8(5) *Copayment.* There will be a $25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition. A copayment will not be imposed when family income is less than 181 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaska Native.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25; **ARC 9952C**, IAB 1/7/26, effective 3/1/26]

441—86.9(514I) Annual reviews of eligibility. All eligibility factors will be reviewed at least every 12 months to establish ongoing eligibility for the program. "Month one" will be the first month in which coverage is provided.

86.9(1) *Review form.* The department will send the family a prepopulated review form on which the answers, except for income, have been completed based on the information on file. The family shall review the completed information for accuracy and fill in the income section of the form. If family income cannot be verified through electronic data matches, the family shall be required to provide verification of current income. The family shall sign and date the form attesting to its accuracy as part of the review process.

86.9(2) *Failure to provide information.* The child shall not be enrolled for the next 12-month period if the family fails to provide information and verification of income or otherwise fails to cooperate in the annual review process. If the completed review form and any information necessary to establish continued eligibility are received within 14 calendar days of the end of an enrollment period, the review form and information will be acted upon as though they had been received timely. If the fourteenth calendar day falls on a weekend or state holiday, the enrollee shall have until the next business day to provide the review form and any information necessary to establish continued eligibility.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.10(514I) Reporting changes. Changes that may affect eligibility shall be reported timely to the department. "Timely" shall mean no later than ten working days after the change occurred. The ten working-day period begins the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change unless the child is emancipated, married, or otherwise in an independent living situation, in which case the child shall be responsible for reporting the change.

86.10(1) *Iowa residence is abandoned.* The abandonment of Iowa residence shall be reported following the move from the state.

86.10(2) *Other insurance coverage.* Enrollment of the child in other health insurance coverage shall be reported.

86.10(3) *Decrease in income.* If the family reports a decrease in income, the department will ascertain whether the change affects the premium obligation of the family. If the change is such that the family is no longer required to pay a premium in accordance with the provisions of rule 441—86.8(514I), premiums will no longer be charged beginning with the month following the month of the report of the change.

86.10(4) *Information reported by a third party.* Information reported by a third party will not be acted upon until the information is verified in accordance with subrule 86.3(7).

86.10(5) *Cooperation.* The provisions of subrule 86.3(7) shall apply when a request for information or verification is made due to a change. In addition, failure of the enrollee or of the person acting on behalf of the enrollee to provide requested information or verification that may affect eligibility for the program shall result in cancellation and recoupment of all payments made by the department on behalf of the enrollee during the period in question.

86.10(6) *Effective date of change in eligibility.*

a. When a change in circumstances has a positive effect on eligibility, the change in eligibility shall be effective no earlier than the month following the month in which the change in circumstances was reported, regardless of when the change was reported.

b. When a change in circumstances has an adverse effect on eligibility, the change in eligibility shall be effective no earlier than the month following the issuance of a timely notification, in accordance with the provisions of rule 441—86.11(514I). When the change in circumstances was not reported timely, as defined in this rule, benefits shall be recouped beginning with the month following the month in which the change occurred.

c. When an anticipated change in circumstances is reported before the change occurs, no action will be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.11(514I) Notice requirements. The applicant will be provided an adequate written notice of the decision regarding the applicant's eligibility for the hawki program. The enrollee will be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice will be timely and adequate as provided in rule 441—16.2(17A).

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.12(514I) Appeals and fair hearings. If the applicant or enrollee disputes a decision to reduce, cancel or deny participation in the hawki program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 2506.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—86.13(514I) Covered services. The benefits provided under the hawki program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act as amended to August 1, 2024.

86.13(1) *Required medical services.* The participating health plan shall cover at a minimum the following medically necessary services:

a. Inpatient hospital services (including medical, surgical, intensive care unit, mental health, and substance abuse services).

b. Physician services (including surgical and medical, and including office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits).

c. Outpatient hospital services (including emergency room, surgery, lab, and x-ray services and other services).

d. Ambulance services.

e. Physical therapy.
f. Nursing care services (including skilled nursing facility services).
g. Speech therapy.
h. Durable medical equipment.
i. Home health care.
j. Hospice services.
k. Prescription drugs.
l. Hearing services.
m. Vision services (including corrective lenses).
n. Translation and interpreter services as specified pursuant to 42 U.S.C. Section 1397ee(a)(1) as amended to August 1, 2024.
o. Chiropractic services.
p. Occupational therapy.

86.13(2) *Abortion.* Payment for abortion shall only be made under the following circumstances:

a. The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.
b. The pregnancy was the result of an act of rape or incest.

86.13(3) *Required dental services.* Participating dental plans shall cover at a minimum the following necessary dental services:

a. Diagnostic and preventive services.
b. Routine and restorative services.
c. Endodontic services.
d. Periodontal services.
e. Cast restorations.
f. Prosthetics.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.14(514I) Participating health and dental plans.

86.14(1) *Licensure.* The participating health or dental plan must:

a. Be licensed by the division of insurance of the department of insurance and financial services to provide health or dental care coverage in Iowa; or
b. Be an organized delivery system licensed by the director to provide health or dental care coverage.

86.14(2) *Services.* The participating health or dental plan shall provide coverage for the services specified in rule 441—86.13(514I) to all children determined eligible.

a. The participating health or dental plan shall make services it provides to hawki enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the health or dental plan.
b. Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.
c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county in which it is licensed and in which a provider network has been established.

86.14(3) *Provider network.* The participating health or dental plan shall establish a network of providers. Providers contracting with the participating health or dental plan shall comply with hawki requirements, which shall include collecting copayments, if applicable.

86.14(4) *Identification cards.* Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

86.14(5) *Marketing.*

a. Participating health and dental plans may not distribute any marketing materials directly or through an agent or independent contractor.
b. All marketing materials require prior approval from the department.

c. At a minimum, participating health and dental plans must provide the following material in writing or electronically:

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the hawki enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(2) All health and dental plan literature and brochures shall be available in English and any other language when enrollment in the health or dental plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the health or dental plan.

d. All health and dental plan literature and brochures shall be approved by the department.

e. The participating health and dental plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health or dental plan may make marketing presentations at the discretion of the department.

86.14(6) *Appeal process.* The participating health or dental plan shall have a written procedure by which enrollees may appeal issues concerning the health or dental care services provided through providers contracted with the health or dental plan and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of the appeal to the enrollee.

c. Establishes time frames that ensure that appeals be resolved within 45 days, except for appeals that involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.

d. Ensures the participation of persons with authority to take corrective action.

e. Ensures that the decision be made by a physician, dentist, or clinical peer not previously involved in the case.

f. Ensures the confidentiality of the enrollee.

g. Ensures issuance of a written decision to the enrollee for each appeal, which shall contain an adequate explanation of the action taken and the reason for the decision.

h. Maintains a log of the appeals that is made available to the department at the department's request.

i. Ensures that the participating health or dental plan's written appeal procedures be provided to each newly covered enrollee.

j. Requires that the participating health or dental plan make quarterly reports to the department summarizing appeals and resolutions.

86.14(7) *Records and reports.* The participating health and dental plans shall maintain records and reports as follows:

a. The health or dental plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the health or dental plan or subcontractor of the health or dental plan, as appropriate, must maintain a medical or dental records system that:

(1) Identifies each medical or dental record by hawki enrollee identification number.

(2) Maintains a complete medical or dental record for each enrollee.

(3) Provides a specific medical or dental record on demand.

(4) Meets state and federal reporting requirements applicable to the hawki program.

(5) Maintains the confidentiality of medical or dental records information and releases the information only in accordance with established policy below:

1. All medical and dental records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, other practitioners, or facilities that are providing services to enrollees under a subcontract with the health or dental plan. This provision also applies to specialty providers who are retained by the health or dental plan to provide services that are infrequently used, which provide a support

system service to the operation of the health or dental plan, or that are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the health or dental plan itself, and other subcontractors that require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, or facilities providing emergency care pursuant to paragraph 86.14(2)*"b."*

4. Written consent is required for the transmission of the medical or dental records information of a former enrollee to any physician or dentist not connected with the health or dental plan.

5. The extent of medical or dental records information to be released in each instance shall be based upon a test of medical or dental necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical and dental records maintained by subcontractors shall meet the requirements of this rule except that written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

b. Each health or dental plan shall provide at a minimum reports and plan information to the department as follows:

(1) A list of providers of services under the plan.

(2) Encounter data on a monthly basis as required by the department.

(3) Other information as directed by the department.

c. Each health or dental plan shall at a minimum provide reports and health or dental plan information to the department as follows:

(1) Information regarding the plan's appeal process.

(2) A plan for a health improvement program.

(3) Periodic financial, utilization and statistical reports as required by the department.

(4) Time-specific reports that define activity for child health care, appeals and other designated activities that may, at the department's discretion, vary among plans, depending on the services covered or other differences.

(5) Other information as directed by the department.

86.14(8) *Payment to the participating health or dental plan.*

a. In consideration for all services rendered by a health or dental plan, the health or dental plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical or dental care and services provided to the enrollees.

b. The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

c. The capitation rate does not include any amounts for the recoupment of losses suffered by the health or dental plan for risks assumed under the current or any previous contract. The health or dental plan accepts the rate as payment in full for the contracted services. Any savings realized by the health or dental plan due to lower utilization from a less frequent incidence of health or dental problems among the enrolled population shall be wholly retained by the health or dental plan.

d. If an enrollee has third-party coverage or a responsible party other than the hawki program available for purposes of payment for medical or dental expenses, it is the right and responsibility of the health or dental plan to investigate these third-party resources and attempt to obtain payment. The health or dental plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.15(514I) Use of donations to the hawki program. If an individual or other entity makes a monetary donation to the hawki program, the department will deposit the donation into the hawki trust fund. The department will track all donations separately and will not commingle the donations with other moneys in the trust fund. The department shall report the receipt of all donations to MAAC.

86.15(1) If the donor specifically identifies the purpose of the donation, regardless of the amount, the donation shall be used as specified by the donor as long as the identified purpose is permissible under state and federal law.

86.15(2) If the donation is less than $5,000 and the donor does not specifically identify how it is to be used, the department will use the moneys in the following order:

a. For the direct benefit of enrollees (e.g., premium payments).

b. For outreach activities.

c. For other purposes as determined by MAAC.

86.15(3) If the donation is more than $5,000 and the donor does not specify how the funds are to be used, MAAC will determine how the funds are to be used.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.16(514I) Recovery.

86.16(1) *Amount subject to recovery from the enrollee or representative.* The department may recover from the enrollee or the enrollee's representative the amount of premiums incorrectly paid to a health or dental plan on behalf of the enrollee due to client error, minus any premium payments made by the enrollee, in accordance with 441—Chapter 11.

a. Premiums incorrectly paid to a health or dental plan on behalf of an enrollee due to an administrative error are not subject to recovery from the enrollee.

b. Payments made by a health or dental plan to a provider of medical or dental services are not subject to recovery from the enrollee regardless of the cause of the error.

86.16(2) *Notification.* The enrollee will be promptly notified when it is determined that funds were incorrectly paid due to a client error. Notification shall include:

a. The name of the person for whom funds were incorrectly paid;

b. The period during which the funds were incorrectly paid;

c. The amount subject to recovery; and

d. The reason for the incorrect payment.

86.16(3) *Recovery.*

a. Recovery shall be made:

(1) From the enrollee when the enrollee completed the application and had responsibility for reporting changes, or

(2) From the enrollee's representative (i.e., the parent, guardian, or other responsible person acting on behalf of an enrollee who is under the age of 19) when the representative completed the application and had responsibility for reporting changes.

b. The enrollee or representative shall repay to the department the funds incorrectly expended on behalf of the enrollee.

c. Recovery may come from income, income tax refunds, lottery winnings, or other resources of the enrollee or representative.

86.16(4) *Appeals.* The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 2506.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—86.17(514I) Supplemental dental-only coverage.

86.17(1) *Eligibility.* Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.2(514I) through 441—86.12(514I) and 441—86.17(514I).

86.17(2) *Premiums.* Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families whose countable income is less than or equal to 167 percent of the federal poverty level for a family of the same size using the modified adjusted gross income methodology or to an eligible child who is an American Indian or Alaska Native.

b. If the family's countable income is equal to or exceeds 168 percent of the federal poverty level but does not exceed 203 percent of the federal poverty level for a family of the same size, the premium is $5 per child per month with a $10 monthly maximum per family.

c. If the family's countable income exceeds 203 percent of the federal poverty level but does not exceed 254 percent of the federal poverty level for a family of the same size, the premium is $10 per child per month with a $15 monthly maximum per family.

d. If the family's countable income exceeds 254 percent of the federal poverty level for a family of the same size, the premium is $15 per child per month with a $20 monthly maximum per family.

e. If the family includes uninsured children who are eligible for both medical and dental coverage under hawki and insured children who are eligible only for dental coverage, the premium will be assessed as follows:

(1) The total premium will be no more than the amount that the family would pay if all the children were eligible for both medical and dental coverage.

(2) If the family has one child eligible for both medical and dental coverage and one child eligible for dental coverage only, the premium will be the total of the health and dental premium for one child and the dental premium for one child.

(3) If the family has two or more children eligible for both medical and dental coverage, no additional premium shall be assessed for dental-only coverage for the children who do not qualify for medical coverage under hawki because they are covered by health insurance.

f. The provisions of subrules 86.8(3) through 86.8(6) apply to premiums specified in this subrule.

86.17(3) *Waiting lists.* Before the provisions of subrule 86.3(10) are implemented, all children enrolled in supplemental dental-only coverage shall be disenrolled from the program.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 514I and 2024 Iowa Acts, Senate File 2385.

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CHAPTER 87
FAMILY PLANNING PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 2/1/31

441—87.1(217) Definitions.

"Applicant" means a person who applies for assistance under the family planning program described in this chapter.

"Authorized agency" means an agency or entity with an executed memorandum of understanding (MOU) with the department authorizing the agency to perform point-of-service eligibility determinations for the family planning program.

"Citizen" or *"citizenship"* includes both citizens of the United States and nationals of the United States as defined in 8 U.S.C. Section 1101(a)(22) as amended to August 1, 2024.

"Family planning services" means pregnancy prevention and related reproductive health services.

"Federal poverty level" means the levels published and updated periodically in the Federal Register by the United States Department of Health and Human Services (DHHS) under the authority of 42 U.S.C. Section 9902(2) as amended to August 1, 2024, and revised annually on April 1.

"INA" means the Immigration and Nationality Act of 1952. All references to the INA herein are as amended to August 1, 2024.

"Member" means a person who has been determined eligible and is a current or former recipient of family planning program services.

"Noncitizen" means the same as the term "alien" as defined at 8 U.S.C. Section 1101(a)(3) as amended to August 1, 2024.

"Qualified noncitizen" means the same as the term "qualified alien" as defined at 8 U.S.C. Section 1641(b) and (c), as amended to August 1, 2024, and refers to a person who is:

1. Lawfully admitted for permanent residence in the United States under the INA;
2. Granted asylum in the United States under Section 208 of the INA;
3. A refugee admitted to the United States under Section 207 of the INA;
4. Paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. A person whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA;
6. Granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. An Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V) as amended to August 1, 2024;
8. A Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7) as amended to August 1, 2024;
9. A battered noncitizen as described in 8 U.S.C. Section 1641(c) as amended to August 1, 2024;
10. Certified as a victim of trafficking as described in Section 107(b)(1)(A) of PL 106-386 as amended to August 1, 2024;
11. An American Indian born in Canada to whom Section 289 of the INA applies or a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e) as amended to August 1, 2024;
12. Under the age of 21 and lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii) as amended to August 1, 2024; or
13. Lawfully residing in the United States in accordance with a Compact of Free Association with the government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of PL 116-260 as amended to August 1, 2024.

"Qualifying quarters" means all of the qualifying quarters of coverage as defined under Title II of the Social Security Act as amended to August 1, 2024, worked by a parent of a noncitizen while the noncitizen was under the age of 18 and all of the qualifying quarters worked by a spouse of the noncitizen during their marriage if the noncitizen remains married to the spouse or the spouse is deceased. No qualifying quarters

of coverage that are creditable under Title II of the Social Security Act as amended to August 1, 2024, for any period beginning after December 31, 1996, may be credited to a noncitizen if the parent or spouse of the noncitizen received any federal means-tested public benefit during the period for which the qualifying quarter is credited.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.2(217) Eligibility. Eligibility for the family planning program will be determined according to the provisions of this rule.

87.2(1) *Persons covered.* Subject to funding as described in subrule 87.7(1) and to the requirements of subrules 87.2(2), 87.2(4), and 87.2(6), assistance for family planning services will be available to the following individuals who are not enrolled in medical assistance pursuant to 441—Chapter 74 or 441—Chapter 75:

a. Women who were enrolled in medical assistance when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months plus 60 days after their pregnancy ended;

b. Women who are under the age of 55, who are capable of bearing children but are not pregnant, and who have household income that does not exceed 300 percent of the federal poverty level as determined pursuant to subrule 87.2(3);

c. Men who are under the age of 55, who are capable of fathering children, and who have household income that does not exceed 300 percent of the federal poverty level as determined pursuant to subrule 87.2(3).

87.2(2) *Furnishing of social security number.* As a condition of eligibility, except as provided by paragraph 87.2(2)*"a,"* an applicant or member must provide to the department or authorized agency, as applicable, all social security numbers issued to each individual (including children) for whom family planning services are sought.

a. The requirement of furnishing a social security number does not apply to an individual who:

(1) Is not eligible to receive a social security number;

(2) Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR §422.104 as amended to March 15, 2022; or

(3) Refuses to obtain a social security number because of a well-established religious objection. For this purpose, a well-established religious objection means that the individual:

1. Is a member of a recognized religious sect or division of a sect; and

2. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

b. If a required social security number has not been issued or is not known, the individual seeking coverage under the family planning program must cooperate with the department or authorized agency, as applicable, in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

87.2(3) *Determination of household income.* The department will determine the countable household income of an individual applying under paragraph 87.2(1)*"b"* or *"c"* as follows:

a. Household composition.

(1) The household includes the applicant or member, any dependent children, as defined below, 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 as amended to August 1, 2024.

(2) Definition of dependent children. A dependent child is one under the age of 18 years or 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.

b. Earned income. All earned income that is received by a member of the household shall be counted except for earnings of a child who is a full-time student as defined in subparagraph 87.2(3)*"a"*(1). Earned income including but not limited to the following will be counted:

(1) Salary.

(2) Wages.

(3) Tips.
(4) Bonuses.
(5) Commissions.
(6) Income from Job Corps.
(7) Earnings from self-employment defined as gross income less the allowable costs of producing the income.

c. Unearned income. The following unearned income of all household members will be counted:
(1) Unemployment insurance benefits.
(2) Child support.
(3) Alimony.
(4) Social security and railroad retirement benefits.
(5) Workers' compensation and disability payments.
(6) Benefits paid by the U.S. Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

d. Deemed income. Income deeming for a sponsored alien will be determined pursuant to subrule 87.2(5).

e. Deductions. Deductions from income will be made for any payments made by household members for the following:
(1) Court-ordered child support, alimony, or spousal support paid to nonhousehold members.
(2) Twenty percent of nonexempt earnings.
(3) Child care expenses or expenses related to care for an incapacitated adult. This deduction cannot exceed $200 per month for each child under the age of two and $175 per month for each adult or child aged two or older.

87.2(4) *Citizenship or alienage requirements.*

a. To be eligible for the family planning program, a person must be one of the following:
(1) A citizen or national of the United States.
(2) A qualified noncitizen continuously present (as described in Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility, under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) at 62 CFR §61415 dated November 11, 1997, as amended to August 1, 2024) in the United States since August 22, 1996.
(3) A qualified noncitizen under the age of 21.
(4) A refugee admitted to the United States under Section 207 of the INA.
(5) A noncitizen who has been granted asylum under Section 208 of the INA.
(6) A noncitizen whose deportation is withheld under Section 243(h) or 241(b)(3) of the INA.
(7) A qualified noncitizen veteran who has an honorable discharge that is not due to alienage.
(8) A qualified noncitizen who is on active duty in the armed forces of the United States other than active duty for training.
(9) A qualified noncitizen who is the spouse or unmarried dependent child of a qualified noncitizen described in subparagraph 87.2(4)*"a"*(7) or *"a"*(8), including a surviving spouse who has not remarried.
(10) A qualified noncitizen who has resided in the United States for a period of at least five years beginning on the date of the qualified noncitizen's entry into the United States with a status within the meaning of subparagraph 87.2(4)*"a"*(1), *"a"*(4), or *"a"*(9) under the definition of "qualified noncitizen" in rule 441—87.1(217).
(11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V) as amended to August 1, 2024.
(12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7) as amended to August 1, 2024.
(13) A certified victim of trafficking as described in Section 107(b)(1)(A) of PL 106-386 as amended to August 1, 2024.
(14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian tribe as defined in 25 U.S.C. Section 450b(e) as amended to August 1, 2024.

(15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of PL 110-181 as amended to August 1, 2024, or to Section 602(b)(8) of PL 111-8 as amended to August 1, 2024.

(16) An Afghan paroled into the United States treated as a refugee pursuant to Section 2502 of PL 117-43 as amended to August 1, 2024.

(17) A qualified noncitizen lawfully residing in the United States in accordance with a Compact of Free Association with the government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of PL 116-260 as amended to August 1, 2024.

(18) A conditional entrant pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980.

b. As a condition of eligibility, all applicants for or members of the family planning program shall attest to their citizenship or qualified noncitizen status by signing the application or review form.

c. Except as provided in paragraph 87.2(4)*"h,"* applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph 87.2(4)*"b"* will present satisfactory documentation of citizenship as described in paragraph 87.2(4)*"d"* or *"e."* A reference to a form in paragraph 87.2(4)*"d"* or *"e"* includes any successor form. An applicant or member who attests to citizenship must also verify the applicant's identity. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation is issued to an applicant or member and continues for 90 days.

(2) Family planning services will be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality.

d. Any one of the following documents must be accepted as satisfactory documentation of citizenship and identity:

(1) A United States passport, including a U.S. passport card issued by the U.S. Department of State, without regard to any expiration date as long as such passport or card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of United States Citizenship.

(4) A valid U.S. state-issued driver's license, but only if the state issuing the license does either of the following prior to issuance of the license:

1. Requires proof of United States citizenship; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian tribe as described at 42 CFR §435.407 as amended to March 15, 2022, including but not limited to a tribal enrollment card, a Certificate of Degree of Indian Blood, a tribal census document, or a document on tribal letterhead issued under the signature of the appropriate tribal official. Acceptable documentation:

1. Identifies the federally recognized Indian tribe that issued the document;

2. Identifies the individual by name; and

3. Confirms the individual's membership, enrollment, or affiliation with the tribe.

(6) Another document that provides proof of United States citizenship 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) as amended to August 1, 2024.

e. Satisfactory documentation of citizenship and identity may also be demonstrated by the combination of any identity document described in paragraph 87.2(4)*"f"* and any one of the following:

(1) A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the U.S. Virgin Islands, American Samoa, Swain's Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986 (CNMI local time)). The birth record document may be issued by a state, commonwealth, territory, or local jurisdiction. If the document shows that the individual was born in Puerto Rico or the Northern Mariana Islands before the applicable date referenced in this paragraph, the individual may

be a collectively naturalized citizen. The following establishes U.S. citizenship for collectively naturalized individuals:

1. Puerto Rico: Evidence of birth in Puerto Rico and the applicant's statement that the applicant was residing in the U.S., a U.S. possession, or Puerto Rico on or after January 13, 1941.

2. CNMI (formerly part of the Trust Territory of the Pacific Islands (TTPI)): Evidence of birth in the CNMI; evidence of TTPI citizenship and residence in the CNMI, the U.S., or a U.S. territory or possession on or after November 3, 1986 (CNMI local time); and the applicant's statement that the applicant did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time); evidence of TTPI citizenship, continuous residence in the CNMI since before November 3, 1981 (CNMI local time); voter registration before January 1, 1975; and the applicant's statement that the applicant did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time); evidence of continuous domicile in the CNMI since before January 1, 1974, and the applicant's statement that the applicant did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time).

NOTE: If a person entered the CNMI as a nonimmigrant and lived in the CNMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(3) A Report of Birth Abroad of a U.S. citizen.

(4) A certificate of birth in the U.S.

(5) A U.S. Citizen I.D. card.

(6) A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency).

(7) A final adoption decree showing the child's name and U.S. place of birth or, if an adoption is not final, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth.

(8) Evidence of U.S. Civil Service employment before June 1, 1976.

(9) A U.S. military record showing a U.S. place of birth.

(10) Documentation that a child meets the requirements of Section 101 of the Child Citizenship Act of 2000 as amended to August 1, 2024 (8 U.S.C. Section 1431).

(11) Medical records, including but not limited to hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(12) A life, health, or other insurance record that indicates a U.S. place of birth.

(13) An official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(14) School records, including preschool, Head Start, and day care, showing the child's name and U.S. place of birth.

(15) Federal or state census records showing U.S. citizenship or a U.S. place of birth.

If the applicant does not have one of the documents listed in paragraph 87.2(4)*"d"* or subparagraphs 87.2(4)*"e"*(1) through *"e"*(15), the applicant may submit an affidavit using a form prescribed by the department, signed under penalty of perjury by another individual who can reasonably attest to the applicant's citizenship. Such affidavit must contain the applicant's name, date of birth, and place of U.S. birth. The affidavit is not required to be notarized.

f. Any of the following documents must be accepted as satisfactory documentation of identity, provided the document has a photograph or other identifying information sufficient to establish identity, including but not limited to name, age, sex, race, height, weight, eye color, or address:

(1) Identity documents listed at 8 CFR §274a.2(b)(1)(v)(B)(1) as amended to March 15, 2022, except a driver's license issued by a Canadian government authority.

(2) A driver's license issued by a state or territory.

(3) A school identification card.

(4) A U.S. military card or draft record.

(5) An identification card issued by the federal, state, or local government.

(6) A military dependent's identification card.

(7) A U.S. Coast Guard Merchant Mariner card.

(8) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(9) Two other documents containing consistent information that corroborates an applicant's identity. Such documents include but are not limited to employer identification cards; high school, high school equivalency, and college diplomas; marriage certificates; divorce decrees; and property deeds or titles.

(10) A finding of identity from a federal agency or another state agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

If the applicant does not have any document specified in subparagraphs 87.2(4)*"f"*(1) through *"f"*(10), the applicant may submit an affidavit using a form prescribed by the department signed under penalty of perjury by another individual who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described in paragraph 87.2(4)*"f."* The affidavit is not required to be notarized.

g. The department or authorized agency, as applicable, must accept a photocopy, facsimile, scanned, or other copy of a document listed in paragraph 87.2(4)*"d," "e,"* or *"f"* to the same extent as an original document, unless information on the submitted copy is inconsistent with other information available or there is reason to question the validity of, or information in, the document. The department must provide assistance in a timely manner to persons who need assistance in securing satisfactory documentation of citizenship or identity.

h. A person for whom an attestation of United States citizenship has been made pursuant to paragraph 87.2(4)*"b"* is not required to present documentation of citizenship and identity for the family planning program 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) as amended to August 1, 2024.

(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) of the Act as amended to August 1, 2024).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act as amended to August 1, 2024.

(4) The person is or was exempted while assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act as amended to August 1, 2024, on the basis of being a child in foster care as defined in Iowa Code section 232.2(20B). This exemption does not apply, and the person is subject to the citizenship and identity documentation requirements described in paragraph 87.2(4)*"c,"* when services under Part B of Title IV as amended to August 1, 2024, were terminated due to failure to meet citizenship requirements.

(5) The person is or was exempted while assisted by foster care as defined in Iowa Code section 232.2(20B) or adoption assistance funded under Part E of Title IV of the federal Social Security Act as amended to August 1, 2024. This exemption does not apply, and the person is subject to the citizenship and identity documentation requirements described in paragraph 87.2(4)*"c,"* when services under Part E of Title IV as amended to August 1, 2024, were terminated due to failure to meet citizenship requirements.

(6) The person has previously presented satisfactory documentation of citizenship and identity, as specified by the United States Secretary of Health and Human Services.

(7) The person was deemed eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as amended to August 1, 2024, on or after July 1, 2006, as the newborn of a Medicaid-eligible mother.

(8) The person was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as amended to August 1, 2024, as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act as amended to August 1, 2024.

i. Except as provided in paragraph 87.2(4)*"h,"* applicants or members for whom an attestation of qualified noncitizen status has been made pursuant to paragraph 87.2(4)*"b"* will present satisfactory documentation of qualified noncitizen status. Satisfactory documentation of qualified noncitizen status is documentation issued by the U.S. Citizenship and Immigration Services (USCIS) (formerly Immigration

and Naturalization Service (INS)) of the Department of Homeland Security that identifies the person's qualified noncitizen status.

87.2(5) *Deeming of sponsor's income.*

a. When a qualified noncitizen admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) as amended to August 1, 2024, on behalf of the qualified noncitizen, the income of the sponsor will be deemed to determine eligibility for the sponsored qualified noncitizen. The amount deemed to the sponsored qualified noncitizen will be the total countable income of the sponsor determined pursuant to paragraphs 87.2(3)*"b"* through *"d."*

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

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

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

c. A battered qualified noncitizen as described in 8 U.S.C. Section 1641(c) as amended to August 1, 2024, is exempt from the deeming of a sponsor's income for 12 months.

d. Deeming of the sponsor's income does not apply when:

(1) The sponsored qualified noncitizen attains citizenship through naturalization pursuant to Chapter 2 of Title II of the INA.

(2) The sponsored qualified noncitizen has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act as amended to August 1, 2024, or can be credited with 40 creditable qualifying quarters as defined in rule 441—87.1(217).

(3) The sponsored qualified noncitizen or the sponsor dies.

(4) The sponsored qualified noncitizen is a child under the age of 21 as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii) as amended to August 1, 2024.

87.2(6) *Residency requirements.* Residency in Iowa is a condition of eligibility for the family planning program.

a. Definition of resident. A resident of Iowa is one:

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

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

b. 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.

87.2(7) *Investigation by quality control or the department of inspections, appeals, and licensing.* As a condition of eligibility, an applicant or member must cooperate with the department when the applicant's or member's case is selected by quality control or the department of inspections, appeals, and licensing for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income does not affect family planning program eligibility. (More information can be found in 481—Chapter 72.) Failure to cooperate will serve as a basis for denial of an application or cancellation of family planning program eligibility. Once a person's eligibility is denied or canceled for failure to cooperate, the person may reapply but cannot be determined eligible until cooperation occurs.

87.2(8) *Funding contingency.* Initial and continuing eligibility for family planning services under this program is subject to the availability of funding appropriated for this purpose.

a. When appropriated funding is exhausted, ongoing eligibility will be terminated and new applications will be denied.

b. When appropriated funding becomes available, applications submitted thereafter will be considered on a first-come, first-served basis, based on the date of approval.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.3(217) Enrollment.

87.3(1) *Application.* An individual who requests assistance for family planning services shall file an application on a form prescribed by the department. A woman eligible under paragraph 87.2(1)*"a"* is not required to file an application for assistance under this program. The department will automatically redetermine eligibility upon loss of other Medicaid eligibility within 12 consecutive months plus 60 days after their pregnancy ended.

87.3(2) *Place of filing.* An application may be filed at any department office or authorized agency.

87.3(3) *Information or verification needed to determine eligibility.* The department or authorized agency, as applicable, will notify the applicant or member, authorized representative, or responsible person in writing of the information or verification required to establish eligibility. This notice must be provided to the applicant or member, authorized representative, or responsible person personally or by mail or fax.

a. The department or authorized agency, as applicable, will allow the applicant or member, authorized representative, or responsible person ten calendar days to supply the information or verification requested.

b. The department or authorized agency, as applicable, may extend the deadline for a reasonable period of time when the applicant or member, authorized representative, or responsible person is making reasonable efforts but is unable to secure the required information or verification.

c. If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department or authorized agency, as applicable, will complete the eligibility determination as though the information or verification were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or member, authorized representative, or responsible person will have until the next business day to provide the information.

87.3(4) *Annual review.* An individual who requests that assistance continue for family planning services shall complete a form prescribed by the department. The member must submit the completed review form before the end of the eligibility period to any location specified in subrule 87.3(2).

87.3(5) *Time limit for decision.* An application or review form will be processed by the department or authorized agency with which the form was filed. A determination of eligibility will be made within 45 days of receipt of the application or review form.

87.3(6) *Notice of decision.* The individual will be notified in writing of the decision regarding eligibility for the family planning program in accordance with 441—Chapter 16.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.4(217) Effective date of eligibility. Subject to the availability of funding appropriated for this purpose, assistance for family planning services under this program will be effective on the first day of the month of application or the first day of the month in which all eligibility requirements are met, whichever is later. Assistance will not be available under this program for any months prior to the month of application.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.5(217) Period of eligibility. Eligibility for family planning services under this program will be limited to a period of 12 months from the effective date of eligibility, or the duration of appropriated funding, whichever is less. A new application or annual redetermination of eligibility is required for benefits to continue beyond 12 months.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.6(217) Reporting changes.

87.6(1) *Required changes to report.* An individual applying for or receiving family planning services under this program shall report the following changes within ten days from the date the change is known:

a. Change in mailing address;

b. No longer a resident of Iowa;

c. A woman becomes pregnant;

d. No longer capable of bearing or fathering children;

e. Becomes Medicaid or Iowa health and wellness plan eligible, except women meeting criteria in paragraph 87.2(1)*"a"*; or

f. Turns 55 years of age.

87.6(2) *Disregard of changes.* An individual found to be eligible upon application or annual redetermination of eligibility will remain eligible for 12 months or the duration of appropriated funding, whichever is less, regardless of any change in income or household size.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.7(217) Funding of family planning services program.

87.7(1) *Distribution of funds.* Distribution of family planning services program funds shall be made to eligible, approved, and participating family planning providers subject to rule 441—87.11(217). Eligible family planning providers shall not include any provider that performs abortions or that maintains or operates a facility where abortions are performed and must attest to this fact. Effective July 1, 2018, eligible family planning providers shall be interpreted to include a distinct location of a nonprofit health care delivery system, if the distinct location provides family planning services but does not perform abortions or maintain or operate as a facility where abortions are performed. For the purposes of this subrule, "nonprofit health care delivery system" means an Iowa nonprofit corporation that controls, directly or indirectly, a regional health care network consisting of hospital facilities and various ambulatory and clinic locations that provide a range of primary, secondary, and tertiary inpatient, outpatient, and physician services. For the purposes of this subrule, "abortion" does not include any of the following:

a. The treatment of a woman for a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death.

b. The treatment of a woman for a spontaneous abortion, commonly known as a miscarriage, when not all of the products of human conception are expelled.

87.7(2) *Recovery.* The department will recover from a member all funds incorrectly expended to or on behalf of the member for family planning program services.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.8(217) Availability of services. Family planning services are payable for an individual enrolled in this program only when care is received at or authorized by a participating family planning provider.

87.8(1) Sterilization is a covered service subject to the limitations in 441—Chapter 78.

87.8(2) Covered services cannot include abortion services.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.9(217) Payment of covered services. Payment for family planning services covered under this chapter, including services authorized but not provided by a participating family planning provider, can be made only to participating family planning providers on a fee schedule determined by the department. Family planning services program funds distributed in accordance with this rule will not be used for direct or indirect costs, including but not limited to administrative costs or expenses, overhead, employee salaries, rent, and telephone and other utility costs, related to providing abortions as specified in subrule 87.7(1).

87.9(1) *Fee schedule.* The fee schedule will include the amount of payment for each service and any limits on the service (e.g., a routine Pap smear is payable once annually).

87.9(2) *Third-party payments.* This program is the payer of last resort for services covered in this chapter. Any third-party payment received by the family planning agency or other provider of services plus any payments under this program cannot exceed the fee schedule allowance.

87.9(3) *Supplementation.* Payment made under this program is to be considered payment in full.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.10(217) Submission of claims.

87.10(1) Family planning providers that participate in the program can submit claims to Iowa Medicaid for services rendered no later than 45 days from the last day of the month in which services were provided.

87.10(2) Following a successful review of the claim, Iowa Medicaid will make payments to the family planning provider subject to the availability of funding and the allocation of available funds under subrule 87.7(1).

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

441—87.11(217) Providers eligible to participate.

87.11(1) Providers must be enrolled with the Iowa Medicaid program, subject to 441—Chapter 79, and otherwise qualified to provide family planning services under Medicaid, subject to the limitations related to abortions, as specified above under subrule 87.7(1). Effective July 1, 2018, as a condition of eligibility as a provider under the family planning services program, each distinct location of a nonprofit health care delivery system will enroll in the program as a separate provider, be assigned a distinct provider identification number, and complete an attestation that abortions are not performed at the distinct location. For the purposes of this subrule, "nonprofit health care delivery system" has the same meaning as provided under subrule 87.7(1).

87.11(2) Process for enrollment. Providers wishing to enroll under the state family planning program must complete the following steps:

a. Must complete enrollment with Iowa Medicaid.

b. Must complete a form prescribed by the department regarding nonprovision of abortions, pursuant to requirements referenced above under subrule 87.7(1).

c. Forms must be sent to the department at P.O. Box 36450, Des Moines, Iowa 50315.

[**ARC 9819C**, IAB 12/10/25, effective 2/1/26]

These rules are intended to implement Iowa Code section 217.41B.

[Filed Emergency ARC 3199C, IAB 7/19/17, effective 7/1/17]
[Filed ARC 3389C (Notice ARC 3198C, IAB 7/19/17), IAB 10/11/17, effective 11/15/17]
[Filed ARC 4069C (Notice ARC 3910C, IAB 8/1/18), IAB 10/10/18, effective 11/14/18]
[Filed ARC 6853C (Notice ARC 6642C, IAB 11/16/22), IAB 2/8/23, effective 4/1/23]
[Filed ARC 9819C (Amended Notice ARC 9466C, IAB 8/6/25; Notice ARC 8711C, IAB 1/8/25), IAB 12/10/25, effective 2/1/26]

CHAPTER 88
SPECIALIZED MANAGED CARE PROGRAMS
[Prior to 2/11/87, Human Services[498]]

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

441—88.1(249A) Definitions.

"Alternate PACE service site" means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

"Capitation payment" means the monthly payment to PACE on behalf of each Medicaid participant for the provision of covered medical and supportive services. Payment is made regardless of whether the participant receives services during the month.

"CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

"Enrollee" means a person who is enrolled in a PACE program.

"Federal PACE regulations" means the standards published in 42 CFR Part 460, "Programs of All-Inclusive Care for the Elderly," as amended to August 1, 2024. These rules will be interpreted so as to comply with the federal PACE regulations.

"Interdisciplinary team" or *"IDT"* means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

"Medicare beneficiary" means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

"PACE enrollment agreement" means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR 460.154 as amended to August 1, 2024.

"Service area" means the specific counties in which a PACE provider may provide services as identified in the PACE program agreement.

The following definitions have the same meaning as set forth in 42 CFR 460.6 as amended to August 1, 2024:

"Contract year"
"Medicaid enrollee"
"Medicare enrollee"
"PACE"
"PACE center"
"PACE organization"
"PACE program"
"PACE program agreement"
"Services"
"Trial period"

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.2(249A) Process for new and expanding PACE organization service areas. This rule establishes the state's process for a potential PACE organization seeking department support and an assurance letter to provide to CMS to establish a new or expanding PACE organization.

88.2(1) *Submission of letter of intent.* A person authorized to act on behalf of an entity seeking approval as a new PACE organization or an existing PACE organization seeking to expand its service area shall submit a request to the department in writing or via email to pace@hhs.iowa.gov. The request shall include the following information:

a. Organizational background, history, and experience with PACE and developing long-term services and supports.

b. Identity and credentials of key personnel, including members of any governing board and the proposed management team for the new or expanded PACE organization.

c. Where the new or expanded PACE center will be located.

d. The proposed opening date of the new or expanded PACE center.

88.2(2) *Evaluation of letter of intent and submission requirements.* The department will review the new or expanding PACE organization's letter of intent. The department will provide written notification to the PACE organization regarding whether the requested counties will be reserved and for how long.

a. If the department agrees to support the PACE organization's plans, the department will issue a detailed request for information with a deadline and a list of submission requirements.

b. The department may release the reserved counties if the potential PACE organization fails to follow the department's instructions or misses the submission deadline.

c. The department reserves the right of final approval and to reject a letter of intent submission.

d. New or expanding PACE organizations must follow all other steps to obtain program approval as outlined in the federal PACE regulations.

e. The department may elect to support more than one PACE organization in any county based on the completed feasibility study.

88.2(3) *State readiness review.* The department may conduct an on-site visit or audit and may request additional information from PACE in connection with an application for approval or expansion. A PACE organization is required to:

a. Hold applicable licenses under state and federal law.

b. Operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes and in accordance with applicable professional standards.

c. Maintain documentation to demonstrate compliance with state and local fire safety codes.

d. Once all state requirements are met, the department will provide to the prospective PACE organization an assurance letter to submit to CMS.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.3(249A) Three-way agreement with Medicare and Medicaid. An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department that meets the requirements in 42 CFR Part 460, Subpart C, as amended to August 1, 2024.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.4(249A) Center administration. The PACE organization shall operate the PACE center effectively and efficiently to maintain the highest physical, mental, and psychosocial well-being of each participant.

88.4(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified and who are acting within the scope of the applicable license, endorsement, registration, recognition, or qualification pursuant to 441—Chapter 77.

88.4(2) *Compliance with federal, state, and local laws and professional standards.* The PACE center must operate and provide services in accordance with all applicable federal, state, and local laws, regulations, and codes, as well as accepted professional standards and principles applicable to the professional providing services.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.5(249A) Safety. The PACE organization must establish, maintain, and follow an infection control plan designed to provide a safe, sanitary, and conformable environment to help prevent the transmission of disease and infection pursuant to 42 CFR 460.74 as amended to August 1, 2024.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.6(249A) Physical environment. The PACE center shall be designed, constructed, equipped, and maintained to protect the health and safety of participants, personnel, and the public pursuant to 42 CFR 460.72 as amended to August 1, 2024.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.7(249A) Program services.

88.7(1) *Required services.* The PACE organization shall provide a benefit package for all participants, regardless of the source of payment, which must include the following pursuant to 42 CFR Part 460, Subpart F, as amended to August 1, 2024:

a. All Medicare-covered items and services.

b. All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.

c. Other services determined necessary by the participant's IDT to improve or maintain the participant's overall health status.

88.7(2) *Excluded services.* The following services are excluded from coverage under PACE pursuant to 42 CFR 460.96 as amended to August 1, 2024:

a. Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following a mastectomy.

b. Experimental medical, surgical, or other health procedures not deemed medically necessary by the IDT.

c. Services furnished outside the United States, except in accordance with 42 CFR 424.122 and 42 CFR 424.124 as amended to August 1, 2024, or as otherwise permitted under the Iowa Medicaid program.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.8(249A) Patient education.

88.8(1) *Use of services.* The PACE organization shall have a process and procedure to orient participants on how to access and request services and supports.

88.8(2) *Participant rights.* The PACE organization shall have a written participant bill of rights and inform participants upon enrollment of the participant's rights and responsibilities in accordance with 42 CFR Part 460, Subpart G, as amended to April 11, 2022.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.9(249A) Grievances and appeals. The PACE organization must have written policies and procedures for identifying and processing service determination requests, grievances, and appeals in accordance with 42 CFR 460.120 through 460.124 as amended to August 1, 2024.

88.9(1) *Written log.* The PACE organization must maintain a written log of all grievances and appeals, including all informal or verbal complaints. The log must include progress notes and method of resolution.

88.9(2) *Submission to the department.* Upon request by the department, the PACE organization must provide documentation related to service determination requests, grievances, and appeals, including the log described in subrule 88.9(1), to the department at its mailing address or via email at pace@hhs.iowa.gov.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.10(249A) Participant enrollment and disenrollment. The PACE organization must comply with the federal enrollment requirements stated in 42 CFR 460.152 through 460.156 as amended to August 1, 2024.

88.10(1) *Eligibility for Medicaid members.* To enroll in a PACE program as an Iowa Medicaid member, a person must meet the eligibility requirements specified in this subrule.

a. Basic eligibility requirements.

(1) The person must be 55 years of age or older.

(2) The person must reside in the service area of the PACE center.

(3) The person must be aged, blind, or disabled pursuant to rule 441—75.25(249A).

(4) The person must meet income and resources requirements described in rule 441—75.5(249A) for persons in a medical institution.

(5) The department must determine that the person meets a nursing facility level of care.

(6) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

b. Other eligibility requirements.

(1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person's health or safety pursuant to the criteria specified in the PACE program agreement.

(2) To continue to be eligible for PACE as an Iowa Medicaid member, a person must meet the annual recertification requirements specified in subrule 88.10(6).

88.10(2) *Effective date of enrollment.* A person's enrollment in the program is effective on the first day of the calendar month following the date PACE receives the signed enrollment agreement pursuant to 42 CFR 460.158 as amended to August 1, 2024.

88.10(3) *Duration of enrollment.* Enrollment continues until the participant's death unless either of the following occurs:

a. The participant voluntarily disenrolls. A PACE participant may voluntarily disenroll from the program without cause at any time. A participant's voluntary disenrollment is effective on the first day of the month following the date PACE receives the participant's notice of voluntary disenrollment.

b. The participant is involuntarily disenrolled. An involuntary disenrollment shall not become effective until the department has determined that PACE has adequately documented acceptable grounds for disenrollment. If a participant is approved by the department for involuntary disenrollment, the effective date of disenrollment is the first day of the next month that begins 30 days after the day PACE sends the notice of disenrollment. For example, notification on June 5 would be effective August 1. Acceptable grounds for an involuntary disenrollment are outlined in 42 CFR 460.164 as amended to August 1, 2024.

88.10(4) *Disenrollment.*

a. When disenrolling a participant, the PACE organization must:

(1) Use the most expedient process allowed under the PACE program agreement;

(2) Coordinate the PACE disenrollment date to seamlessly reenroll the person in Medicare Part A, B, and D and Medicaid for a participant who is dually eligible for both Medicare and Medicaid; and

(3) Give reasonable advance notice to the participant.

b. Until the date when enrollment is terminated, the following requirements must be met:

(1) The PACE organization must continue to furnish all needed services.

(2) The participant must continue to use PACE services.

88.10(5) *Documentation of disenrollment.* The PACE organization must:

a. Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.

b. Make documentation available for review by CMS and the department.

c. Use the information on voluntary disenrollments in PACE's internal quality improvement program.

d. Provide the department with information regarding all participant disenrollments, including voluntary, involuntary, and deaths. PACE must complete a form prescribed by the department and submit it to the department in the manner directed by the department within ten days of the date of disenrollment or death.

88.10(6) *Medicaid eligibility review.*

a. When requested by the department, the participant shall complete a form prescribed by the department in accordance with rule 441—76.14(249A).

b. At least annually, the department will:

(1) Evaluate whether each participant continues to meet the nursing facility level of care; and

(2) Review of all financial and nonfinancial eligibility pursuant to 441—Chapter 76.

c. Deemed continued eligibility. If the department determines that a participant no longer meets the nursing facility level of care, the department, in consultation with the PACE organization, will determine whether, in the absence of continued PACE coverage, the participant reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination will be based on a review of the participant's medical record and plan of care, applying criteria specified in the PACE program agreement. If the participant reasonably would be expected to meet the level-of-care requirement within six months, the participant's eligibility for the PACE program may continue until the next annual reevaluation.

88.10(7) *Reinstatement in other Medicare and Medicaid programs.* After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former participant's reinstatement in other Medicare and Medicaid programs by:

a. Assisting in transitions to other Medicare plans and Medicaid programs for which the participant may be eligible; and

b. Making appropriate referrals and ensuring that medical records are made available to new providers within 30 days from the participant's last day of enrollment with PACE.

88.10(8) *Reinstatement in PACE.* A previously disenrolled participant may be reinstated in a PACE program. If the reason for disenrollment is failure to pay the premium and the participant pays the premium before the effective date of disenrollment, the participant is reinstated in the PACE program with no break in coverage pursuant to 42 CFR 460.170 as amended to August 1, 2024.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.11(249A) Records and reports.

88.11(1) *Records.* A PACE organization shall maintain clinical and fiscal records in accordance with federal and state requirements, including but not limited to rule 441—79.3(249A) and 42 CFR 460.200 as amended to August 1, 2024.

88.11(2) *Content of individual treatment record.* A PACE organization shall ensure that participating providers and subcontractors maintain adequate records and documentation that include a complete medical or service record for each enrolled participant pursuant to rule 441—79.3(249A).

88.11(3) *Confidentiality of health care, mental health care, and substance abuse information.* The PACE organization shall protect and maintain the confidentiality of health care, mental health care, and substance abuse information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.12(249A) Health Insurance Portability and Accountability Act of 1996 (HIPAA). The PACE organization and its subcontractor shall protect each participant's privacy in accordance with the confidentiality requirements stated in 45 CFR Parts 160 and 164 as amended to August 1, 2024. The PACE organization must report any HIPAA breach by the organization or its subcontractors to the department, using a form prescribed by the department.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.13(249A) Funding.

88.13(1) *Medicaid capitation payments to the PACE organization.* Under a three-way agreement, the department will make a prospective capitation payment to the PACE organization.

a. The amount of the capitation payment:

(1) Will be an actuarially sound rate determined in accordance with federal funding requirements that is less than the amount that would otherwise have been paid (AWOP) under the Medicaid program if the participant had not been enrolled in the PACE program.

(2) Will be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

b. The PACE organization must accept the capitation payment amount as payment in full for Medicaid members. The PACE organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the Medicaid member except for any amounts due from the participant pursuant to subrule 88.13(2).

c. To facilitate rate development, the PACE organization must supply financial information to the department in the format requested by the due date.

88.13(2) *Client participation for payment of medical institution care.* A PACE participant shall contribute toward the cost of the participant's care according to the amount determined by Medicaid eligibility pursuant to rule 441—75.16(249A).

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

441—88.14(249A) Federal and state monitoring; sanctions.

88.14(1) The PACE program shall comply with federal and state monitoring requirements described in 42 CFR Part 460, Subpart K, as amended to August 1, 2024.

88.14(2) Within 30 days of issuance of review results, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

88.14(3) The department will monitor the effectiveness of the corrective actions implemented by the PACE organization.

88.14(4) The PACE program is subject to sanctions or termination pursuant to 42 CFR Part 460, Subpart D, as amended to August 1, 2024.

[**ARC 9280C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code chapter 249A.

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◊ Two or more ARCs

1 Effective date of 8/1/88 delayed 30 days by the Administrative Rules Review Committee at its July 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.

CHAPTER 89
DEBTS DUE FROM TRANSFERS OF ASSETS

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—89.1(249F) Definitions.

"Fair market value" means the price for which property or an item could have been sold on the open market at the time of transfer.

"Medical assistance" means the same as defined in Iowa Code section 249F.1.

"Property" means the same as defined in Iowa Code section 702.14.

"Transfer" means the disposal of property for less than fair market value through gifting, sale or any transfer or assignment of a legal or equitable interest in property.

"Transferee" means the person who receives a transfer or assignment of a legal or equitable interest in property for less than fair market value.

"Transferor" means the person who makes a transfer of a legal or equitable interest in property for less than fair market value.

[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.2(249F) Creation of debt.

89.2(1) *Transfer of property.* Except as provided in rule 441—89.3(249F), any transfer of property for less than fair market value creates a debt due and owing to the department from the transferee if:

a. The transfer is made while the transferor is receiving medical assistance or within five years prior to application for medical assistance and between July 1, 1993, and December 31, 2018.

b. The transfer is made with the intent on the part of the transferee of enabling the transferor to obtain or maintain eligibility for medical assistance.

89.2(2) *Amount of debt.* The amount of the debt is the lesser of:

a. An amount equal to the medical assistance provided to or on behalf of the transferor on or after the date of the transfer.

b. The difference between the fair market value of the property at the time of transfer and the value of any consideration received.

[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.3(249F) Exceptions. Notwithstanding rule 441—89.2(249F), transfers detailed in Iowa Code section 249F.1(3)*"b"* that occur on or after July 1, 1996, do not create a debt to the department.

[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.4(249F) Presumption of intent. Any transfer of property for less than fair market consideration made while the transferor is receiving medical assistance or within five years prior to an application for medical assistance is presumed to be made with the intent, on the part of the transferee, of enabling the transferor to obtain or maintain eligibility for medical assistance. This presumption can be rebutted only by clear and convincing evidence that the transferor's eligibility or potential eligibility for medical assistance was no part of the transferee's reason for accepting the transfer of property.

[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.5(249F) Notice of debt. The department may issue a notice establishing and demanding payment of an accrued or accruing debt due and owing to the department as provided in rule 441—89.2(249F) pursuant to Iowa Code section 249F.3(1).

[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.6(249F) No timely request of a hearing. If a timely written request for hearing is not received by the department, the department may enter an order pursuant to Iowa Code section 249F.3(3) and 249F.3(4).

[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.7(249F) Timely request for a hearing. If a timely written request for a hearing is received by the department, the department will certify the matter for hearing to the district court pursuant to Iowa Code section 249F.4.
[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.8(249F) Department-requested hearing. The department may also request a hearing on its own motion regarding the determination of a debt at any time prior to entry of an administrative order.
[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.9(249F) Filing and docketing of the order. An order may be filed pursuant to Iowa Code section 249F.5(1). The department's order shall be presented, ex parte, to the district court for review and approval.
[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

441—89.10(249F) Exemption from Iowa Code chapter 17A. Actions initiated under Iowa Code chapter 249F are not subject to Iowa Code chapter 17A. Review by the district court shall be an original hearing before the district court.
[**ARC 9313C**, IAB 5/28/25, effective 8/1/25]

These rules are intended to implement Iowa Code chapter 249F.

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CHAPTER 90
FEE-FOR-SERVICE CASE MANAGEMENT

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

441—90.1(249A) Definitions.

"Adult" means a person 18 years of age or older on the first day of the month in which service begins.

"Applicant" means a person who has applied for an HCBS waiver or habilitation program.

"Case management" means the categories of case management: targeted case management (TCM) and case management provided to members enrolled in a 1915(c) waiver.

"Case manager" means the staff person providing the case management services regardless of the entity providing the service.

"Child" means a person other than an adult.

"Chronic mental illness" means a condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. The definition of chronic mental illness and qualifying criteria are found in 441—Chapter 24. For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Core standardized assessment" or *"CSA"* means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant's or member's needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs.

"Developmental disability" means a severe, chronic disability that is determined through professionally administered screening and evaluations.

"Fee-for-service member" or *"FFS member"* means a member who is not enrolled with a managed care organization.

"Home- and community-based services" or *"HCBS"* means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act as amended to July 1, 2026.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in 441—Chapter 83.

"Major incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, TCM, or habilitation services and 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, a report of dependent adult abuse pursuant to Iowa Code section 235B.3, or a report of elder abuse pursuant to Iowa Code chapter 235F;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in numbered paragraph "1," "2," or "3"; or
7. Involves a member's location being unknown by provider staff who are responsible for protective oversight.

"Managed care organization" or *"MCO"* means the same as defined in 441—Chapter 73.

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 CFR Section 435.1009 as amended to October 20, 2022.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, TCM, or habilitation services and that is not a major incident but 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.

"Person-centered service plan" or *"service plan"* means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member's guardian or representative, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a member may share a residence.

"Targeted case management" or *"TCM"* means case management services furnished to assist members who are part of a targeted population.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; or
2. A child who is eligible to receive HCBS waiver services according to 441—Chapter 83.

A member enrolled with an MCO is not part of the targeted population.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.2(249A) Targeted case management. This rule applies only to the case management category of TCM and the defined targeted population.

90.2(1) *Eligibility for targeted case management.* A person who meets all of the following criteria will be eligible for TCM:

a. The person is eligible for Medicaid or is conditionally eligible under 441—Chapter 75;

b. The person is a member of a targeted population;

c. The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);

d. The person has applied for TCM in accordance with the policies of the provider;

e. The person is not eligible for or enrolled in an MCO.

90.2(2) *Determination of need for targeted case management.* Assessment at least every 365 days since the date of identified need for TCM is required as a condition of eligibility under the medical assistance program. The TCM provider manual found on the department's website and as amended to July 1, 2026, contains more information.

90.2(3) *Application for targeted case management.* The TCM provider shall process a received application for TCM no later than 30 days after receipt of the application. The Medicaid manual for TCM found on the department's website and as amended to July 1, 2026, has more information.

a. Application decision for targeted case management. The TCM provider shall inform the applicant, or the applicant's guardian or representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements in 441—Chapter 16.

b. Denial of applications. The TCM provider will deny an application for service when:

(1) The applicant is not currently eligible for Medicaid;
(2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);
(3) The applicant, or the applicant's guardian or representative, withdraws the application;
(4) The applicant does not provide information required to process the application;
(5) The applicant is receiving duplicative TCM from another Medicaid provider; or
(6) The applicant does not have a need for TCM.

90.2(4) *Transition to a community setting.* The Medicaid manual for TCM found on the department's website and as amended to July 1, 2026, contains information about services that may be provided to a member transitioning to a community setting.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.3(249A) Termination of TCM services.

90.3(1) TCM shall be terminated only when:

a. The member does not meet eligibility criteria under rule 441—90.2(249A);

b. The member has achieved all goals and objectives of the service;

c. The member has no ongoing need for TCM;

d. The member is receiving TCM based on eligibility under an HCBS program but is no longer eligible for the program;

e. The member or the member's guardian or representative requests termination;

f. The member is unwilling or unable to accept further services; or

g. The member or the member's guardian or representative fails to provide access to information necessary for the development of the service plan or for implementation of TCM.

90.3(2) The provider shall notify the member or the member's guardian or representative in writing of the termination of TCM, in accordance with 441—Chapter 16.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.4(249A) Case management services. This rule applies to all categories of case management and all populations covered by case management.

90.4(1) *Covered services.* The following shall be included in FFS case management services provided to members.

a. Assessment. Initial assessments and regular reassessments must be completed for each member to determine the need for medical, social, educational, housing, transportation, vocational, or other services, as specified in the Medicaid manual for TCM found on the department's website and as amended through July 1, 2026.

b. Person-centered service plan. The case manager shall develop and revise a comprehensive, person-centered service plan at least every 365 days in accordance with the Medicaid manual for TCM found on the department's website and as amended to July 1, 2026.

c. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member.

d. Contacts. The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly. The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face-to-face or by telephone.

90.4(2) *Exclusions.* Payment will not be made for activities otherwise within the definition of case management services when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred.

c. The activities are components of the administration of foster care programs.

d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act as amended to August 1, 2025.

e. The activities duplicate institutional discharge planning.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.5(249A) Rights restrictions. This rule applies to all categories of case management and all populations covered by case management. Any effort to restrict the rights of a member, or the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. For more information, refer to the Person Centered Service Plan manual as amended to July 1, 2026, available on the department's website.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.6(249A) Documentation and billing. This rule applies to all categories of case management and all populations covered by case management. The case management billing manual for case management contact documentation and billing requirements available on the department's website and as amended to July 1, 2026, contains more information.
[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.7(249A) Case management services provider requirements.

90.7(1) This rule applies to all categories of case management and all populations covered by case management. Major or minor incidents shall be reported according to the case management incident reporting manual available on the department's website and as amended to July 1, 2026.

90.7(2) Quality assurance. Case management services providers shall cooperate with quality assurance activities conducted by Iowa Medicaid, as well as any other state or federal entity with oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include but are not limited to:

a. Postpayment review of case management services;
b. Review of incident reports;
c. Review of reports of abuse or neglect; and
d. Technical assistance in determining the need for service.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code section 249A.4.

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[1] January 1, 2003, effective date of 90.2(5) and 90.3 delayed 70 days by the Administrative Rules Review Committee at a special meeting held December 19, 2002.

CHAPTER 91
MEDICARE DRUG SUBSIDY

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—91.1(249A) Definitions.

"Applicant" means a person applying for a Medicare drug subsidy through the department and includes a responsible person or authorized representative acting for an applicant, except for the purposes of subrule 91.2(2).

"Application" or *"Medicare drug subsidy application"* means the federal Social Security Administration's Form SSA-1020B-OCR-SM, Application for Help with Medicare Prescription Drug Plan Costs.

"Authorized representative" means a person representing an applicant or recipient as described in 441—subrule 76.9(2).

"Recipient" means a person receiving a Medicare drug subsidy based on an application filed with the department and includes a responsible person or authorized representative acting for a recipient, except for the purposes of subrule 91.2(2).

"Responsible person" means a person acting on an applicant's or recipient's behalf as described in 441—subrule 76.9(1).

[**ARC 9314C**, IAB 5/28/25, effective 8/1/25]

441—91.2(249A) Application.

91.2(1) *Application filing.* Any person may apply for the Medicare drug subsidy through the department in accordance with 441—Chapter 76.

91.2(2) *Identifiable application and signature.*

a. An identifiable application is an application that contains:

(1) The legible name and address of the applicant; and

(2) The signature of the applicant, a responsible person, or an authorized representative on Form SSA-1020B-OCR-SM, Application for Help with Medicare Prescription Drug Plan Costs.

b. If an authorized representative signed the application forms on behalf of an applicant, the applicant or a responsible person must also sign the application forms before the application can be approved.

[**ARC 9314C**, IAB 5/28/25, effective 8/1/25]

441—91.3(249A) Eligibility determination. The department will determine eligibility for the Medicare drug subsidy pursuant to Section 1860D-14 of the Social Security Act and implement federal regulations at 20 CFR Section 418 as amended to August 1, 2024.

91.3(1) *Cooperation.* An applicant must cooperate with the department in the application process. Cooperation may include providing additional information or verification of information, participating in an interview, or signing documents. Failure to cooperate in the application process shall be a basis for denial of an application.

91.3(2) Reserved.

[**ARC 9314C**, IAB 5/28/25, effective 8/1/25]

441—91.4(249A) Effective date. The effective date of eligibility will be determined pursuant to 42 CFR Part 423 as amended to August 1, 2024.

[**ARC 9314C**, IAB 5/28/25, effective 8/1/25]

441—91.5(249A) Changes in circumstances.

91.5(1) *Responsibility to report changes.* A Medicare drug subsidy applicant or recipient shall report to the department in a timely manner any changes in the following circumstances:

a. Care of dependents.

b. Household composition.

c. Household income.

d. Household resources.

e. Marital status.
f. Medicare eligibility or enrollment.
g. Place of residence.

91.5(2) *Effective date of change.* Changes in eligibility or level of subsidy will be effective the month following the month in which the change is reported.
[**ARC 9314C**, IAB 5/28/25, effective 8/1/25]

441—91.6(249A) Reinvestigation. The department will reinvestigate eligibility as often as the recipient's circumstances indicate, but in no instance will the period between reinvestigations exceed 12 months.

91.6(1) *Application requested.* When requested to do so by the department, the recipient shall complete the Medicare drug subsidy application as part of the reinvestigation process. The application shall be completed within ten working days from the date a written request is issued. Failure to complete the application shall be a basis for cancellation or reduction of the subsidy.

91.6(2) *Additional information requested.* The recipient shall supply additional information needed to establish eligibility or level of subsidy pursuant to 441—Chapter 76.
[**ARC 9314C**, IAB 5/28/25, effective 8/1/25]

441—91.7(249A) Appeals. An applicant or recipient shall have the right to appeal any adverse action by the department pursuant to 441—Chapter 2506.
[**ARC 9314C**, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 217.6 and 249A.4 and Section 1935(a) of the Social Security Act (42 U.S.C. Section 1396u-5).

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CHAPTER 92
IOWACARE
Rescinded **ARC 2361C**, IAB 1/6/16, effective 1/1/16

TITLE IX
WORK INCENTIVE DEMONSTRATION

CHAPTER 93
PROMISE JOBS PROGRAM
[Prior to 7/1/89, see 441—Chapters 55, 59 and 90]

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

441—93.1(239B) Definitions.

"Applicant" means a child for whom assistance is being requested under the family investment program, any parent living in the home with the child, and any nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child.

"FaDSS" means the family development and self-sufficiency program operated under 441—Chapter 49, which provides in-home family development services to families at risk of instability or long-term FIP dependency.

"Family investment agreement" or *"FIA"* means the agreement developed with a participant in accordance with Iowa Code section 239B.8.

"FIA-responsible person" means any member of the FIP applicant family unless exempt as described in 441—subrule 41.24(2). More information is contained in subrule 93.4(2).

"FIP" means the family investment program authorized in Iowa Code chapter 239B.

"Limited benefit plan" or *"LBP"* means a period of time in which a participant or member of a participant's family is either ineligible for any assistance under the FIP or eligible for reduced assistance in accordance with Iowa Code section 239B.9.

"Needy specified relative" means a nonparental specified relative as defined in 441—subrule 41.22(3) who meets all the eligibility requirements to be included in the FIP.

"Participant" for purposes of the PROMISE JOBS program means a person who has signed an FIA and is approved to receive FIP benefits, a parent or relative living in the home of a child approved to receive FIP benefits, or a person reconsidering a subsequent LBP.

"PROMISE JOBS program" means the promoting independence and self-sufficiency through employment, job opportunities, and basic skills program created in Iowa Code section 239B.17.

"TANF" means Title I Block Grants for Temporary Assistance for Needy Families (PL 109-171) (reauthorized 2006 and as amended to August 1, 2024).

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.2(239B) Program administration. The department will administer an employment and training program known as PROMISE JOBS.

93.2(1) *Availability of service.* PROMISE JOBS services shall include but are not limited to those listed in paragraph 93.4(4)*"b."*

a. The program shall be available statewide. If the department determines that sufficient funds are not available to offer services on location in each county, the department will prioritize the availability of services to those counties having the largest FIP populations.

b. Because of state and federal budgetary limitations, federal mandatory work requirements, requirements for minimum participation rates, and other TANF requirements imposed on the PROMISE JOBS program, the department will have the administrative authority to:

(1) Determine agency and geographical breakdowns for service;

(2) Designate specific groups for priority services; and

(3) Designate specific PROMISE JOBS components or supportive service levels for a waiting list.

93.2(2) *Contracts with provider agencies.* The department may contract with the department of workforce development, the department of economic development, or other appropriate entity to provide PROMISE JOBS services and case management of those services.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.3(239B) Registration and referral.

93.3(1) *Registration for PROMISE JOBS.* Unless the department determines a person is exempt as specified in 441—subrule 41.24(2), an application for FIP assistance constitutes a registration for the PROMISE JOBS program and acceptance of the requirement to enter into an FIA for all members of the FIP case and all other persons responsible for the FIA as specified in rule 441—41.24(239B).

93.3(2) *Referral.* The department will refer all FIA-responsible persons from FIP applicant and participant households to PROMISE JOBS pursuant to 441—subrule 41.24(4).

93.3(3) *Initial appointment.*

a. FIP applicants. FIP applicants, including those who are in an LBP, will be offered an appointment with the PROMISE JOBS provider agency for orientation, assessment, and FIA development at the earliest available time. The provider agency shall make sufficient appointment times available to allow the applicant to be scheduled no later than ten calendar days after the date of the notice that FIA responsibility has begun as required by rule 441—93.4(239B), 441—paragraphs 41.24(1)*"c"* and *"d,"* and 441—paragraph 41.24(10)*"g."*

b. Exempt status change. Persons who become FIA-responsible while receiving FIP shall initiate PROMISE JOBS orientation and FIA development by contacting the appropriate PROMISE JOBS office to schedule an appointment within ten calendar days of the mailing date of the letter explaining that exempt status has been lost and FIA responsibility has begun as required by 441—subrule 41.24(5). If the person fails to schedule an appointment or fails to appear for an appointment, PROMISE JOBS shall send one written reminder letter that informs the person that those who do not develop an FIA shall enter into an LBP. If the person fails to schedule an appointment within ten calendar days of the written reminder letter or fails to appear for an appointment scheduled after the written reminder letter is sent, the person shall enter into an LBP as described in 441—paragraph 41.24(8)*"c."*

93.3(4) *Orientation.* Every person referred to PROMISE JOBS shall receive orientation services. PROMISE JOBS workers shall provide FIA orientation.

a. During orientation, each applicant shall receive a full explanation of:

(1) The advantages of employment under the family investment program (FIP), including information on earned income tax credits;

(2) Services available under PROMISE JOBS;

(3) Participant rights and responsibilities under the FIA and PROMISE JOBS;

(4) The LBP as described in 441—subrule 41.24(8);

(5) The availability of family planning counseling services in the area and the financial implications of newly born children on the participant's family.

b. Each applicant shall receive a form prescribed by the department, confirming that information described in paragraph 93.3(4)*"a"* has been provided.

93.3(5) *Initial meeting.* The PROMISE JOBS worker shall meet with each referred person, or with the family if another parent or a child is also referred to PROMISE JOBS, to:

a. Determine participation activities,

b. Establish expenses and a schedule for supportive payments, and

c. Discuss child care needs.

93.3(6) *Workforce development registration.* Each applicant is required to register for work with the department of workforce development, upon request by the PROMISE JOBS worker.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.4(239B) FIA. The FIA is the condition of and basis for PROMISE JOBS services and is an eligibility requirement for the FIP as specified in rule 441—41.24(239B).

93.4(1) *Development.* An initial FIA shall be developed during the orientation and assessment process through discussion between the FIA-responsible person and the PROMISE JOBS worker. For the FIA to be considered completed, an FIA shall be signed by all of the following:

a. The FIA-responsible person or persons.

b. Other family members who are referred to PROMISE JOBS.

c. The PROMISE JOBS worker.

d. The PROMISE JOBS supervisor.

93.4(2) *FIA-responsible persons.* All members of the FIP applicant family shall develop and sign an FIA unless exempt as described in 441—subrule 41.24(2). When an FIA-responsible person is incompetent or incapacitated, someone acting responsibly on that person's behalf may participate in the interview. Responsibility for carrying out the steps of the FIA ends at the point that FIP assistance is not provided to the participant or when a participant becomes exempt.

a. Parents. All parents who are not exempt from PROMISE JOBS shall be responsible for signing and carrying out the activities of the FIA. Parents of any age are exempt only if they are receiving Supplemental Security Income (SSI) or they are not U.S. citizens and are not qualified aliens as defined in rule 441—40.21(239B). When the FIP-eligible group includes a minor parent living with one or both parents or a needy specified relative who receives FIP as described in 441—subparagraph 41.28(2)*"b"* (2) and none is exempt from PROMISE JOBS participation, each parent or needy specified relative is responsible for a separate FIA.

b. Teens. Participants aged 16 to the participants' nineteenth birthday shall be responsible for signing and carrying out the activities of the FIA unless they are receiving SSI or they attend school full-time.

(1) When the FIP-eligible group includes one or both parents or a needy specified relative and a child or children and none is exempt from PROMISE JOBS participation, all shall be asked to sign one FIA with the family and to carry out the activities of that FIA rather than signing separate FIAs.

(2) When the FIP-eligible group includes one or both parents or a needy specified relative who is exempt from PROMISE JOBS participation and a child or children who are not exempt, each child is responsible for completing a separate FIA.

(3) A minor nonparental specified relative who is not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

c. Other adults. All other adults who are not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

93.4(3) *FIA content.* The FIA shall include the goals of the family for achieving self-sufficiency and shall establish a time frame with a specific ending date, during which the family expects to become self-sufficient and after which FIP benefits will be terminated. For individuals and families with acknowledged barriers, one or more incremental FIAs may be written.

a. All FIAs shall:

(1) Outline the expectations of the PROMISE JOBS program and of the family;

(2) Clearly establish interim goals and FIA activities necessary to reach long-term goals and self-sufficiency;

(3) Identify barriers to participation so that the FIA may include a plan, appropriate referrals, and supportive services necessary to eliminate or manage the barriers;

(4) Stipulate specific services to be provided by the PROMISE JOBS program, including child care assistance, transportation assistance, family development services, and other supportive services;

(5) Include the participant's responsibility to provide verification of hours of participation, and how and when the verification will be submitted;

(6) Record a participant's response to the option of referral for family planning counseling as described in subrule 93.9(3).

b. Plans from other agencies. The FIA may incorporate a self-sufficiency plan that the family has developed with another agency or person, subject to the following requirements:

(1) The participant shall authorize PROMISE JOBS to obtain the self-sufficiency plan and to arrange coordination with the manager of the self-sufficiency plan by signing a release of information prescribed by the department.

(2) The self-sufficiency plan may be included in the participant's FIA if the self-sufficiency plan meets the requirements of this chapter and is deemed by the PROMISE JOBS worker to be appropriate to the family circumstances.

93.4(4) *Participation requirements.* The FIA shall require the FIA-responsible persons and family members who are referred to PROMISE JOBS to choose participation in one or more activities as described in this subrule.

a. Goals. It is expected that employment leading to economic self-sufficiency is the eventual goal of the FIA.

(1) To the maximum extent possible, the FIA shall reflect the goals of the family, subject to program rules; funding; the capability, experience, and aptitudes of family members; and the potential market for the job skills currently possessed or to be developed.

(2) The program goal for all participants is to be involved in PROMISE JOBS activities on a full-time basis unless problems or barriers prohibit this level of involvement. "Full-time" is considered an average of at least 30 hours per week. Exceptions to full-time involvement are identified in rule 441—93.14(239B) and subrule 93.4(5).

b. Activities. Except as specified in 441—paragraph 93.4(4)*"c,"* PROMISE JOBS activities may include but are not limited to any combination of the following activities:

(1) Orientation as described in subrule 93.3(4).

(2) Assessment as described in rule 441—93.5(239B).

(3) Job readiness and job search activities, including job readiness skills training and other activities that prepare a participant to search for or obtain employment, individual and structured job search, unplanned job opportunities, mental health treatment, substance use disorder treatment, or other rehabilitative activities, as described in rule 441—93.6(239B).

(4) Work activities, including part-time or full-time employment, self-employment, on-the-job training, work experience placement, or unpaid community service as described in 441—93.7(239B).

(5) Educational activities, including high school completion, high school equivalency diploma (HSED) certification, adult basic education (ABE), English as a second language (ESL) training, vocational training, or postsecondary training up to and including a baccalaureate degree as described in 441—93.8(239B).

(6) Parenting skills training as described in subrule 93.9(1).

(7) Participation in the FaDSS program or other family development programs as described in subrule 93.9(2).

(8) Referral for family planning counseling as described in subrule 93.9(3).

(9) Family violence option as described in subparagraph 93.4(5)*"b"*(4).

(10) Services provided by other agencies.

c. FIA activities for participants aged 16 to 19. Development of FIA activities shall follow these guidelines for participants aged 16 to 19.

(1) Participants aged 16 to 19 who are not parents and who have not completed high school shall be strongly encouraged to participate in educational activities to obtain a high school diploma or the equivalent. A high school education is recognized as important to achieving self-sufficiency. Participants shall be given information on the earning power of people with a high school education compared to those who do not so that participants are able to make an informed choice. If high school or high school equivalency completion is not included in a teenager's FIA, other FIA activities shall be required. High school or high school equivalency completion shall be proposed and reconsidered at the next FIA review.

(2) Parents under the age of 18 who are not married and who have not completed high school shall be expected to use enrollment or continued attendance in high school or involvement in a high school equivalency program as a first step in the FIA, except when the parent is deemed incapable of participating in these activities by the local education agency.

(3) Parents aged 19 and younger shall include parenting skills training as described in subrule 93.9(1) in their FIA, or the case file shall include documentation that this requirement has been fulfilled.

(4) Parents under the age of 18 who are not married and who do not live with a parent or legal guardian shall include FaDSS, as described in 441—Chapter 49, or other family development services as described in subrule 93.9(2) in the FIA. The FaDSS or other family development services shall continue after the parent reaches the age of 18 only when the participant and the family development worker believe that the services are needed for the family to reach self-sufficiency.

d. FIA activities for participants convicted of a drug-related felony after August 22, 1996. A participant convicted of a drug-related felony after August 22, 1996, shall include drug rehabilitation

activities in the participant's FIA to verify that the participant does not illegally possess, use, or distribute a controlled substance except when:

(1) The participant successfully completed any applicable drug rehabilitation and court-ordered probation or parole resulting from the drug felony conviction, or

(2) The participant is currently on probation or parole and successfully completed all drug rehabilitation requirements resulting from the drug felony conviction, whether court-ordered or required by probation or parole.

e. Waiting lists. The department of health and human services reserves the authority to prioritize services to FIP applicants and participants in the order that best fits the needs of FIP applicants and recipients and PROMISE JOBS program participants. Participants who are placed on a waiting list for a PROMISE JOBS component shall include other appropriate activities in the FIA while waiting unless family circumstances indicate otherwise.

(1) Persons shall be removed from these waiting lists and placed in components at the discretion of state-level PROMISE JOBS administrators in order to help participants achieve self-sufficiency in the shortest possible time, meet budgetary limitations, enable participants to make maximum use of other programs, fulfill the federal minimum participation rate requirements, and meet other TANF requirements.

(2) Persons who were enrolled in approved postsecondary training at the time of FIP cancellation shall not be placed on a postsecondary training waiting list if the participant is still satisfactorily participating in approvable training at the time that FIP eligibility is regained.

f. Unavailability of funding. If funding for the PROMISE JOBS activities included in a participant's FIA or required supportive payments are not available, the participant's FIA shall be renegotiated to include different activities.

93.4(5) *Barriers to participation.* Problems with participation of a permanent or long-term nature shall be considered barriers to participation and shall be identified in the FIA as issues to be resolved or managed so that maximum participation can result.

a. Barriers defined. Barriers to participation include anything identified by an FIA-responsible person that prevents them from fully participating in PROMISE JOBS.

b. Inclusion in FIA.

(1) When barriers are identified by the applicant during initial assessment, removal or management of the barrier shall be part of the FIA from the beginning.

(2) When barriers are revealed by the participant or are identified by problems that develop after the FIA is signed, the FIA shall be renegotiated and amended to provide for removal or management of the barriers.

(3) In limited instances where special-needs care for a child or adult is not available, it may be most practical for the participant to develop the FIA to identify providing the care as part of the FIA.

(4) Victims of domestic violence may include in their FIA the family violence option, which is a plan to address or attempt to prevent domestic violence. The family violence option may allow for a temporary waiver from participation in PROMISE JOBS activities when appropriate for the participant or participant's situation.

(5) The PROMISE JOBS worker shall review the need for inclusion of a barrier to participation in the FIA at least once every six months to determine if the barrier continues to exist.

c. Cooperation with removing or managing barriers.

(1) Applicants. An FIA-responsible applicant who chooses not to cooperate in removing or managing barriers to participation identified during FIA development shall be denied FIP.

(2) Participants. A participant who chooses not to cooperate in removing or managing identified barriers to participation shall be considered to have chosen the LBP. If the participant claims a cognitive or physical disability or mental illness that is expected to last for more than 12 consecutive months, the participant is required to apply for social security disability and supplemental security income benefits. When the participant refuses to apply for those benefits, the FIP household is ineligible for FIP as described at 441—subrule 41.27(1), and the LBP does not apply.

93.4(6) *Failure to complete an FIA.*

a. FIP applicants. An applicant's failure to develop or sign an FIA will result in denial of the family's application for FIP assistance as described in 441—paragraphs 41.24(4)*"a"* through *"c."*

b. FIP participants. FIP participants who choose not to enter into an FIA or who choose not to continue its activities after signing an FIA shall enter into the LBP as described in 441—subrule 41.24(8).

93.4(7) *Progress reviews.* The PROMISE JOBS worker shall review all FIAs at least once every six months with input from at least one family member. FIA goals and, if appropriate, the needs for child care, transportation, and other supports shall be reviewed for continued appropriateness.

93.4(8) *Renegotiation.*

a. The FIA shall be renegotiated to reflect a new plan for self-sufficiency if:

(1) The participant has participated satisfactorily in the current FIA activities but is not self-sufficient by the end date specified in the FIA; or

(2) The participant demonstrates effort in carrying out the steps of the FIA but is unable to participate satisfactorily in the current FIA activities due to a barrier as described in subrule 93.4(5); or

(3) The participant's circumstances change to such an extent that the current FIA activities are no longer appropriate.

b. Participants who choose not to cooperate in the renegotiation process when requested by PROMISE JOBS shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.4(9) *Reinstatement.* When a participant who has signed an FIA loses FIP eligibility and has not become exempt from PROMISE JOBS at the time of FIP reapplication, the contents of the original FIA and the participant's responsibility for carrying out the steps of that FIA may be reinstated when the steps of the FIA fit the family's current circumstances. The FIA shall be renegotiated and amended if needed to accommodate changed family circumstances.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.5(239B) Assessment. The purpose of assessment is to provide an evaluation of the FIP applicant or participant family that furnishes a basis for the PROMISE JOBS worker to determine: (1) family members' employability and educational potential, so that participants can make well-informed choices; and (2) the services that will be needed for the family to achieve self-sufficiency, so that the worker can provide appropriate guidance.

93.5(1) *Initial assessment.* All persons referred to PROMISE JOBS shall complete an initial assessment, which includes a form prescribed by the department and shall review, at a minimum, the family's basic needs as determined by the department. This initial assessment shall be used to develop the initial FIA. The PROMISE JOBS worker shall meet individually with FIA-responsible persons.

93.5(2) *Additional assessments.* Additional assessments may include but are not limited to literacy and aptitude testing, educational level and basic skills assessment, evaluation of job interests or job skills, occupation-specific assessment or testing, or an evaluation of past pertinent information. An additional assessment may be used by mutual agreement between the PROMISE JOBS worker and the participant as a tool and to help explore possible FIA development. For a specific additional assessment to be required, completion of the assessment must be specified in the FIA.

a. Additional information on applicants. If information identified during the initial assessment indicates that further information is needed to help the participant and PROMISE JOBS worker identify appropriate FIA activities and level of involvement, the applicant shall complete additional assessments as determined by the PROMISE JOBS worker. Completion of this assessment may be the first step in the initial FIA.

b. Medical examination. The PROMISE JOBS worker may require a person to complete a medical examination before including a particular PROMISE JOBS activity in the FIA when a participant specifies or exhibits any condition that might jeopardize successful participation in the program. The worker shall ask the health practitioner to indicate to the best of the practitioner's knowledge whether the person is capable of completing the FIA activity or continuing with appropriate employment.

c. Rehabilitation assessments. At any time during the assessment process or as more information is revealed, a referral may be made for professional assessments in physical health, mental health, substance use disorder, or other rehabilitative services.

d. Additional information on participants. Assessments may be completed or redone at any time throughout the development and duration of the FIA if the information is needed to help the participant and the PROMISE JOBS worker make decisions concerning the type or level of the participant's involvement in PROMISE JOBS activities.

93.5(3) *Postsecondary educational evaluation.* Participants who wish to include postsecondary education in their FIA shall complete an educational evaluation to determine the likelihood of success.

a. Request for education resulting in a vocational certificate or certificate of completion. Vocational certificate or certification of completion training programs offer short-term training in a specific vocational area. The PROMISE JOBS worker shall determine the likelihood of success using the following types of tools or information:

(1) A review of information from past training situations,
(2) Past job performance in comparable positions,
(3) Basic skills tests,
(4) Career-specific assessments,
(5) A specific standardized test, or
(6) Other key historical information.

b. Request for education resulting in an associate or baccalaureate degree. The PROMISE JOBS worker shall determine the likelihood of academic success through an educational evaluation. The evaluation may include use of the following types of tools or information:

(1) Standardized assessments in reading comprehension, math, and writing skills;
(2) Occupation-specific skills assessments;
(3) Interest inventories;
(4) Current or past grades; and
(5) Other pertinent historical information.

c. Documenting educational evaluation results. When a participant has requested education to be included in the FIA, the PROMISE JOBS worker shall document:

(1) What formal assessments were completed, if any, and what the results were;
(2) What other information was reviewed;
(3) How the evaluation information was used by the PROMISE JOBS worker in either approving or denying the inclusion of education in the participant's FIA; and
(4) Whether the request is approved or denied. If the request is denied, PROMISE JOBS shall issue a Notice of Decision: Services to the participant as required in paragraph 93.10(1)*"b."*

93.5(4) *Substituting or supplementing an assessment.*

a. Substituting assessment information. If the FIA-responsible person's mental status, physical status, and life situation have not changed significantly, comparable assessment information completed with another agency or person within the past two years may be used instead of performing new assessments.

(1) Examples of agencies or persons that may complete comparable assessment information include but are not limited to the department of workforce development, Head Start, public housing authorities, child welfare workers, vocational rehabilitation services, an educational institution or testing service, or family development services.

(2) The FIA-responsible person may authorize PROMISE JOBS to obtain these assessment results by signing a release of information prescribed by the department.

b. Supplementing assessment information. In order to ensure that the FIA activities do not conflict with any case plans that have already been established for the family, the FIA-responsible person may:

(1) Supplement assessment information, and
(2) Establish communication between the PROMISE JOBS worker and other agencies or persons.

c. Use of key historical information. When key historical information, such as a review of the participant's job history or past training outcomes, relays a clear picture of the participant's skills and abilities, a formal, standardized educational assessment may not be needed.

(1) If a participant is currently enrolled in or has been enrolled in comparable training or an academic program in the past two years, the evaluation of the participant's performance, including grades received, may be substituted for a formal, standardized educational assessment.

(2) When using historical information as an indicator of future success, changes in the participant's mental status, physical status, life circumstances, and motivation shall be given consideration.

93.5(5) *Assessment after FIP cancellation or LBP.* FIP participants who previously participated in either a basic or additional assessment and then were canceled from FIP or entered an LBP may be required to complete an assessment again when the PROMISE JOBS worker determines that updated information is needed for development or amendment of the FIA.

93.5(6) *Participants with FaDSS services only.* For participants with FaDSS services as the only activity in their FIA, the PROMISE JOBS worker shall use information provided by the FaDSS worker to help assess when a participant is ready to participate in other PROMISE JOBS activities. The PROMISE JOBS worker may require additional assessments to be completed if more information is needed to decide the type or level of the participant's involvement in other PROMISE JOBS activities.

93.5(7) *Documenting participation.* The participant shall provide documentation of participation in assessments as described in subrule 93.10(2). Persons who miss any portion of a scheduled assessment may be required to make up the missed portion, based on worker judgment and participant needs.

93.5(8) *Supportive payments allowed.* Except for assessment activities that occur on the same day as orientation, persons participating in assessment activities are eligible for child care assistance and transportation payments needed to allow the scheduled participation as described in rule 441—93.11(239B). When make-up sessions are required, the participant shall not receive an additional transportation payment, but necessary child care assistance shall be paid.

93.5(9) *Failure to complete assessment.* Participants who do not complete assessments that are written into their FIA shall be considered to have chosen the LBP unless they have good cause. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.6(239B) Job readiness and job search activities. Job readiness and job search activities include job readiness skills training and other activities that prepare a participant to search for or obtain employment, individual and structured job search, unplanned job opportunities, substance use disorder treatment, mental health treatment, and other rehabilitation activities. The participant and the PROMISE JOBS worker shall incorporate into the FIA the job readiness and job search activities that are appropriate for the goals, work history, skill level, and life circumstances of the participant.

93.6(1) *Job readiness.* Job readiness prepares participants to search for or obtain employment. Job readiness consists of job readiness skills training and other activities completed outside of a training session that prepare a participant to search for or obtain employment.

a. Delivery of job readiness skills training. Job readiness skills training is provided in scheduled sessions consisting of up to 30 hours of structured activity per week.

b. Job readiness skills training. Job readiness skills training may include but is not limited to:

(1) Interests and skills assessment;
(2) Self-esteem building and motivational exercises;
(3) Identifying and eliminating employment barriers;
(4) Résumé development;
(5) Completing job applications and follow-up letters;
(6) Obtaining interviews and communication skills;
(7) Interviewing skills development;
(8) Goal attainment planning;
(9) Soft skills and life skills;
(10) Job market trends and finding job leads;
(11) Self-marketing and positive attitude building; and
(12) Job retention skills.

c. Other job readiness activities. Job readiness may include activities that prepare the participant to search for or obtain employment and are completed outside of a training session.

d. Attendance. Attendance is required when a participant is scheduled for job readiness skills training or other job readiness activities unless the participant has good cause as described in rule 441—93.14(239B) or a barrier as described in subrule 93.4(5). Participants who miss any portion of job

readiness skills training may be required to either make up the missed portion of the sessions or to retake the entire week of training based on practical worker judgment and participant need.

e. Supportive payments allowed. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed to participate in job readiness skills training or other job readiness activities. The transportation payment shall be paid before the first scheduled day of participation.

(1) Participants who must repeat or make up any portion of job readiness skills training because of absence due to reasons as described in rule 441—93.14(239B) shall receive an additional transportation payment as described in subrule 93.11(3) for each day that must be repeated and child care assistance. This rule applies only when the participant will have transportation costs that exceed the participant's original payment because of repeating or making up a portion of job readiness skills training.

(2) Participants who must repeat or make up any portion of job readiness skills training as a result of absences due to reasons other than those described at rule 441—93.14(239B) shall not receive an additional transportation payment.

f. Documenting job readiness skills training or other job readiness participation. Hours of participation in job readiness skills training or other job readiness activities shall be documented as described in subrule 93.10(2).

g. Failure to participate in job readiness skills training activities. Participants who without good cause do not appear for scheduled job readiness skills training activities as stated in the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.6(2) *Individual job search.* Individual job search shall be available to all participants, particularly those who have recent ties with the workforce, have successfully removed or reduced barriers to work, have completed job readiness skills training, or have completed education or training activities and are now ready to work. Participants are not required to participate in individual job search full-time. Individual job search may be combined with other FIA activities to reach full-time equivalency. Hours of participation in individual job search shall be determined according to the participant's individual circumstances and be at a level that will reasonably allow the participant to successfully find full-time employment. If after three calendar months the participant still has not found employment, the worker shall review the participant's situation for possible barriers to employment or possible need for training to increase the participant's employability. Job search may continue if appropriate, but linking with other activities should be considered.

a. Job search plan. A written job search plan using a form prescribed by the department shall be developed with input from the PROMISE JOBS participant and the PROMISE JOBS worker. A copy shall be provided to the participant. The plan shall:

(1) Contain a designated period for job search not to exceed five weeks ending on a Friday within the same calendar month and the specific methods for finding job openings.

(2) Specify the number of hours to be committed for each week of the designated period so as to provide the most effective use of transportation funds.

(3) Specify due dates for providing documentation of job search activities.

(4) Contain information as specific as possible about areas of employment interest, employers to be contacted, and other pertinent factors.

b. Supportive payments allowed. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed for participation in an individual job search. The transportation payment shall be paid in full prior to the start of each designated period of the individual job search. Transportation payments for any missed days of job search activity shall be subject to transportation overpayment policies as described in subrule 93.11(3).

c. Documenting job search participation. The participant shall document the actual hours spent on job contacts and other job search activities. Participant documentation shall be provided as described in subrule 93.10(2).

d. Failure to participate in individual job search. Participants who without good cause do not participate in the steps of the job search plan described at paragraph 93.6(2)*"a"* shall be considered to have

chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.6(3) *Unplanned job opportunity.* PROMISE JOBS participants who have an unplanned opportunity to interview or apply for a job shall be encouraged to take advantage of the opportunity.

a. Supportive payments allowed. Child care assistance and transportation payments needed to make an unplanned job contact shall be provided as described in rule 441—93.11(239B) when the following conditions are met:

(1) The participant has a signed FIA,

(2) The job contact requires transportation to complete an application or to attend an interview, and

(3) The participant provides documentation as described in paragraph 93.6(3)*"b."* Payment shall be issued after documentation is received.

b. Documenting participation. The participant shall provide documentation of the actual time spent making the specific job contact. Documentation shall be provided as described in subrule 93.10(2).

c. LBP. An LBP does not apply when a participant fails to complete a job contact that is not part of a structured or individual job search plan.

93.6(4) *Structured job search.* Structured job search is designed with scheduled activities and required hours of participation to reflect proven job search techniques and the employment environment of the PROMISE JOBS service area. A PROMISE JOBS worker is available to monitor the participant's progress in the participant's job search and to provide assistance and support. Structured job search provides up to 30 hours of scheduled activity. Hours of participation in structured job search shall be determined according to the participant's individual circumstance and may be full-time or at a level that will reasonably allow the participant to successfully find full-time employment.

a. Attendance. Participants are scheduled to appear daily at the PROMISE JOBS site to access resources for job leads. Participants who miss any portion of scheduled structured job search may be required to either make up the missed portion of the session or to retake the entire week of training based on practical worker judgment and participant need.

(1) Participants who obtain employment averaging 30 hours or more per week may discontinue structured job search.

(2) Participants who obtain employment averaging 20 hours or more per week, but less than 30 hours per week, may discontinue structured job search if part-time employment was the FIA goal or the scheduled job search hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with employment hours.

(3) Participants who obtain employment averaging less than 20 hours per week shall continue structured job search unless the scheduled job search hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with employment hours.

b. Job search plan. A written job search plan using a form prescribed by the department shall be developed with input from the PROMISE JOBS participant and the PROMISE JOBS worker. A copy shall be provided to the participant. The plan shall:

(1) Contain a designated period for job search and the specific methods for finding job openings.

(2) Specify the number of hours to be committed for the designated period so as to provide the most effective use of transportation funds.

(3) Specify the due date for providing documentation of job search activities.

(4) Contain information as specific as possible about areas of employment interests, employers to be contacted, and other pertinent factors.

c. Supportive payments allowed. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed to participate in structured job search.

d. Documenting participation. The PROMISE JOBS worker shall verify and document each participant's monthly hours of actual participation in structured job search. Participant documentation shall be provided as described in subrule 93.10(2).

e. Failure to participate in structured job search. Participants who without good cause do not complete structured job search as identified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.6(5) *Substance use disorder treatment, mental health treatment, and other rehabilitative activities.* Substance use disorder or mental health treatment or other rehabilitative activities are available when needed for a participant to be successful in participating in other FIA activities.

a. Treatment determination. The need for treatment or rehabilitative activities must be determined by a qualified medical professional, substance use disorder professional, or mental health professional. The qualified professional must document that treatment or rehabilitative activities are needed for the participant to obtain or retain employment.

b. Supportive payments allowed. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed to participate in substance use disorder treatment, mental health treatment, or other rehabilitative activities.

c. Documenting participation. The service provider shall verify actual hours of participation in treatment. Documentation of participation shall be provided as described in subrule 93.10(2).

d. Failure to participate in treatment or other rehabilitative activities. Participants who without good cause do not participate in substance use disorder treatment, mental health treatment, or other rehabilitative activities as specified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.7(239B) Work activities. Work activities include full-time employment, part-time employment, self-employment, on-the-job training, work experience placement, and unpaid community service. The participant and the PROMISE JOBS worker shall incorporate into the FIA employment activities that are appropriate for the work history, skill level, and life circumstances of the participant. If the FIA activity is so hazardous that safety glasses, hard hats, or other safety equipment is needed, participation shall not be arranged or approved unless these safety precautions are available.

93.7(1) *Full-time or part-time employment.* FIAs may include full-time employment or part-time employment. Employment that does not lead to economic self-sufficiency may be included in the FIA only if the employment situation leads to better employment opportunities through building work skills and work history. More information about additional policies applicable to self-employment is contained in subrule 93.7(2).

a. Full-time employment. The goal for all participants is to participate in full-time employment. "Full-time employment" is defined as being employed an average of 30 or more hours per week.

(1) Persons who have not achieved self-sufficiency through full-time employment before the end date of the FIA may have the FIA extended.

(2) Persons who choose not to enter into the renegotiation process to extend the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

b. Part-time employment. Part-time employment is defined as being employed an average of less than 30 hours per week. An FIA that includes part-time employment shall also include participation in other PROMISE JOBS activities, including additional part-time employment, unless barriers to participation exist as defined in rule 441—93.14(239B) and subrule 93.4(5).

c. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care assistance shall be provided as described in rule 441—93.11(239B) when needed for employment.

d. Verification of employment hours. Participants must provide verification of employment hours as described in subrule 93.10(2).

e. Failure to provide verification. Failure to provide verification of work hours after receiving a written reminder letter will result in an LBP.

f. Failure to maintain employment. A participant who without good cause does not maintain employment as identified in the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.7(2) *Self-employment.*

a. Calculation of hours. Hours of participation for persons who are self-employed shall be calculated using actual gross income less business expenses divided by the federal minimum wage. PROMISE JOBS shall use the same income as used for FIP eligibility and benefits.

(1) Participants with self-employment income that equates to 30 or more hours per week are considered to be working full-time.

(2) Participants with self-employment income that equates to less than 30 hours per week are considered to be working part-time.

b. Review of participation. The PROMISE JOBS worker shall review calculated hours:

(1) When income changes, or

(2) At least once every six months.

c. Progress toward self-sufficiency. At the participant's FIA review, the participant's progress is determined by noting incremental increases in income and calculated work hours. In order to maintain self-employment as the only FIA activity, participants must:

(1) Reach full-time employment as defined in subparagraph 93.7(2)*"a"*(1), or

(2) Show progress toward self-sufficiency.

d. Requiring other FIA activities. When a participant has been self-employed for more than 12 months and has not shown progress toward self-sufficiency, the FIA shall include the part-time self-employment in combination with participation in other PROMISE JOBS activities unless barriers to participation exist as defined in subrule 93.4(5) and rule 441—93.14(239B).

(1) The other activities could include additional part-time employment.

(2) When the determination that a participant has not shown progress toward self-sufficiency is made after the initial FIA is developed, the FIA shall be renegotiated to include the other PROMISE JOBS activities. Participants who choose not to enter into the FIA renegotiation process shall enter into an LBP as described in 441—subrule 41.24(8). Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

e. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care assistance shall be provided as described in subrule 93.11(2) when needed for participation in self-employment.

f. Supportive payments not allowed. Funds may not be used to purchase supplies to enable a participant to begin a private business.

g. Documenting participation. Hours of participation in self-employment shall be calculated as specified in paragraph 93.7(2)*"a"* and documented in the case file. Participant documentation shall be provided as described in subrule 93.10(2).

h. Failure to maintain employment. Participants who without good cause do not maintain employment as identified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.7(3) *On-the-job training.*

a. Definition. "On-the-job training" is defined as training in the public or private sector that:

(1) Is given to a paid employee while the employee is engaged in productive work, and

(2) Provides knowledge and skills essential to the full and adequate performance of the job.

b. Supportive payments. Transportation for on-the-job training is treated in the same manner as transportation for employment. Expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care assistance shall be provided as described in subrule 93.11(2) when needed for participation in on-the-job training.

c. Documenting participation. Documentation of participation shall be provided as described in subrule 93.10(2).

d. Failure to participate in on-the-job training. Participants who without good cause do not participate in on-the-job training as identified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.7(4) *Work experience program.* Work experience sites shall provide participants with work experience.

a. Sponsors. Employers who participate in the work experience program are referred to as sponsors. Work experience sponsors may be public sector, private sector, community-based, faith-based, or nonprofit employers.

(1) Participants may be placed at work sites with religious institutions only when the work performed is nonsectarian and not in support of sectarian activities.

(2) Participants may not be used to replace regular employees in the performance of nonsectarian work for the purpose of enabling regular employees to engage in sectarian activities.

(3) Each work experience program sponsor shall provide to the PROMISE JOBS service provider a copy of the sponsor's safety rules before participants are referred for work-site placement.

b. Positions. To request a work experience placement, the sponsor shall complete a form prescribed by the department for each type of position the sponsor wishes to fill. The request shall include a complete job description that specifies all tasks to be performed by the participant. PROMISE JOBS has final authority to determine suitability of any work experience position offered by a sponsor. Work experience positions:

(1) Must contain the same job description and performance requirements that would exist if the sponsor were hiring an employee for the same position;

(2) Shall not be related to political, electoral, or partisan activities;

(3) Shall not be developed in response to or in any way be associated with the existence of a strike, lockout, or other bona fide labor dispute;

(4) Shall not violate any existing labor agreement between employees and employers;

(5) Shall comply with applicable state and federal health and safety standards;

(6) Shall not be used by sponsors to displace current employees or to infringe on the promotional opportunities of current employees;

(7) Shall not be used in place of hiring staff for established vacant positions; and

(8) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

c. Participant selection. A participant's vocational skills and interests shall be matched as closely as possible with the job description and skills required by the sponsor.

(1) Participant responsibility. Participants shall interview for and accept positions offered by work experience sponsors. Participants shall present a form prescribed by the department to the sponsor at the interview. The form shall be completed by the sponsor and returned to PROMISE JOBS.

(2) Sponsor responsibility. Although sponsors are expected to accept work experience referrals made by PROMISE JOBS, sponsors may refuse any referrals they deem inappropriate for the available position. Sponsors shall not discriminate against any program participant because of race, color, religion, sex, age, creed, physical or mental disability, political affiliation, or national origin. Sponsors who refuse a referral must notify PROMISE JOBS in writing of the reason for the refusal.

d. Hours of participation. When a participant is involved in work experience that is subject to the Fair Labor Standards Act (FLSA) as amended to August 1, 2024, the participant cannot be required to work more hours than the amount of the monthly FIP grant divided by federal or state minimum wage, whichever is higher. Exception: To determine the maximum hours that can be required of a single-parent family on FIP with a child under the age of six, add the value of the family's Supplemental Nutrition Assistance Program (SNAP) benefits to the FIP grant amount before dividing by the minimum wage.

(1) A participant cannot be required to work more hours than those calculated under paragraph 93.7(4) *"d."* Only hours up to or less than that calculation can be included in the participant's FIA.

(2) If two or more members of the same household participate in work experience, the total required hours of participation of the household cannot exceed the hours calculated according to paragraph 93.7(4) *"d."*

(3) Each work experience assignment shall not exceed six months in duration.

e. Participant performance evaluations.

(1) Monthly evaluations. Sponsors shall complete a monthly evaluation of the participant's performance using a form prescribed by the department and provide a copy to PROMISE JOBS and to the participant.

(2) Final evaluations. Sponsors shall complete a form prescribed by the department at the time of termination for each work experience participant. When termination occurs at the sponsor's request, the sponsor shall specify the reason for termination and identify those areas of unsatisfactory performance. For participants who leave to accept regular employment or reach their work experience placement time limit, the sponsor's evaluation shall indicate whether or not a positive job reference would be provided if the participant requested one.

f. Supportive payments for work experience placements.

(1) Child care and transportation. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed for participation in work experience.

(2) Required clothing and equipment. The sponsor will provide a documented list of clothing and equipment required by the work experience site. A participant may receive a one-time supportive expense payment per work-site assignment for clothing or equipment that is documented by the sponsor and that cannot be obtained from the sponsor or other resources.

(3) Workers' compensation. The department will provide workers' compensation coverage for all PROMISE JOBS work experience participants.

g. Documenting participation. Documentation of participation shall be provided as described in subrule 93.10(2).

h. Completion of work experience. Persons who complete a work experience assignment may move to another activity as provided under the FIA, be assigned to a different work site, or be reassigned to the same work site, whichever is appropriate under the FIA.

i. Failure to participate in work experience. A participant who without good cause does not participate in work experience as identified in the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.7(5) *Unpaid community service.*

a. Work sites. Unpaid community service work sites shall be public or private nonprofit organizations. The PROMISE JOBS provider agencies shall provide community service work sites a written explanation of the following placement criteria. The placement:

(1) Shall comply with applicable state and federal health and safety standards;

(2) Shall not be related to political, electoral or partisan activities;

(3) Shall not be developed in response to or in any way associated with the existence of a strike, lockout, or other bona fide labor dispute;

(4) Shall not violate any existing labor agreement between employees and employers;

(5) Shall not be used to displace current employees or to infringe on their promotional opportunities;

(6) Shall not be used in place of hiring staff for established vacant positions; and

(7) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

b. Locating the work site. When a participant and the PROMISE JOBS worker agree that an unpaid community service placement is appropriate, PROMISE JOBS shall assist the participant in identifying potential work sites. The participant is responsible for locating and making arrangements with the work site. Formal interviews are not required to establish the relationship between the participant and the work-site organization.

c. Length of assignment and weekly hours. The length of the work-site assignment and the weekly hours of participation shall be determined through agreement among the work-site organization, the participant, and the PROMISE JOBS worker. When a participant is involved in community service that is subject to the FLSA as amended to August 1, 2024, the participant cannot be required to work more hours than the amount of the participant's monthly FIP grant divided by federal or state minimum wage, whichever is higher. Only hours up to or less than the maximum calculated may be included in the participant's FIA. Exceptions are as follows:

(1) For a participant who is a single parent with a child under the age of six, the maximum hours that can be required are determined by adding the value of the participant's SNAP to the FIP grant amount before dividing by the minimum wage.

(2) Participants who are court-ordered to do community service shall work the number of hours required by the court.

d. Supportive payments. Child care assistance and a transportation payment for each month of participation or part thereof shall be paid as described in rule 441—93.11(239B) when needed for participation in unpaid community service.

e. Documenting participation. Documentation of participation shall be provided as described in subrule 93.10(2).

f. Failure to complete unpaid community service. Participants who without good cause do not participate in unpaid community service as specified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.8(239B) Education and training activities. Education refers to any academic or vocational course of study that enables a participant to complete high school, improves a participant's ability to read and speak English, or prepares a participant for a specific professional or vocational area of employment. Though employment leading to economic self-sufficiency is the eventual goal of all FIAs, it is recognized that education increases a person's chance of finding employment, particularly employment that leads to economic self-sufficiency. Any participant who requests participation in educational activities shall be evaluated to determine the likelihood of success. If the request is approved, a training plan shall be developed and included in the participant's FIA.

93.8(1) *Participant requirements.* The decision to include education in an FIA shall take into account the results of the educational evaluation pursuant to paragraph 93.8(1)*"b"* and the current educational level of the participant. Prior academic or vocational training is not, in itself, a reason for denial or approval of educational services. All family members who are approved for education shall be eligible for all program benefits, even when two or more family members are simultaneously participating and even if participation is at the same educational facility and in the same program. For education to be approved for inclusion in an FIA, the following requirements shall be met.

a. Vocational goal. For a participant enrolled in postsecondary education, the education must lead to a specific vocational goal. A degree in general studies or programs not leading to specific occupational outcomes cannot be included in a participant's FIA.

(1) Except as provided in subparagraph 93.8(1)*"a"*(2), a vocational goal must be in an occupational field for which available labor market information or emerging business trends in the participant's local area indicate employment potential. These trends or statistics must be provided by a legitimate source.

(2) Information to support employment potential in the participant's local area is not required when:

1. The participant has a documented job offer in the field before entering the training; or
2. The participant is willing to relocate after training to an area where there is employment potential. Documentation for the new location shall meet the requirements in subparagraph 93.8(1)*"a"*(1).

(3) For participants attending high school or high school equivalency activities, adult basic education or English as a second language, the vocational goal is to improve employability by successfully completing the activity.

b. Educational evaluation. An educational evaluation shall be completed according to subrule 93.5(3) before postsecondary education is included as an FIA activity. A participant under the age of 19 does not need to complete an educational evaluation in order to have high school completion included in the FIA.

(1) A participant who chooses to enter educational activities before obtaining approval is not eligible to receive supports as described in subrule 93.8(6), cannot use that activity to meet the FIA participation obligation, and shall be expected to participate in other FIA activities.

(2) A participant who is already involved in education at the time of FIP application or enters education before approval must meet the requirements in this rule before the educational activities can be included in the FIA. Once approved, the current educational activity may then be included in the participant's FIA, and the participant will be eligible to receive supports as described in subrule 93.8(6).

93.8(2) *Provider requirements.* Both public and private agencies may provide educational activities.

a. Type of provider. Education may be included in the FIA if obtained from a provider that is approved or registered with the state or is accredited by an appropriate accrediting agency. Training provided by a community action program, church, or other agency may be included in the FIA only if PROMISE JOBS determines that:

(1) The training is adequate and leads to the completion of the participant's vocational goal; and

(2) The training provider possesses appropriate and up-to-date equipment; has qualified instructors, adequate facilities, a complete curriculum, acceptable evaluation methods, and a good job-placement history; and demonstrates expenses of training that are reasonable and comparable to the costs of similar programs.

b. Time and attendance. The provider must verify the participant's actual hours of attendance in an educational activity with a form prescribed by the department pursuant to subrule 93.10(2). If the educational activity is structured in such a way that verification cannot be obtained or the educational provider is unwilling to provide time and attendance verification, the educational activity cannot be included in the participant's FIA. Exceptions apply for online or distance learning as described in paragraph 93.10(2)*"f"* and for participants under age 20 as described in subparagraph 93.10(2)*"b"*(3).

93.8(3) *Approvable activities.* Training plans shall include only training activities that can be considered as meeting the FIA obligations for participation. The following activities may be included in a training plan:

a. Adult basic education.

b. Continuing education units when needed for the participant to be recertified or retrained to reenter a field in which the participant was previously trained or employed or to maintain certification needed to remain employed.

c. Correspondence courses when the courses are required but not offered by an educational facility attended by the participant.

d. English as a second language.

e. High school or high school equivalency completion. Any participant who does not have a high school diploma or high school equivalency diploma (HSED) shall be encouraged to obtain a diploma. A participant who is 18 years of age or older may be approved to return to regular high school only when the participant can graduate within one year of the normal graduation date. High school equivalency or high school courses and other types of vocational training may run concurrently.

f. Online or distance learning. The training:

(1) Must include interaction between the instructor and the student;

(2) Must include mechanisms for evaluation and measurement of student achievement; and

(3) Must be offered in Iowa unless the conditions in paragraph 93.8(3)*"g"* apply. An online training program shall be considered an out-of-state training program when any of the required training or testing occurs out-of-state.

g. Out-of-state training. Out-of-state training is approvable only when:

(1) Similar training is not available in Iowa,

(2) Relocation required to attend an in-state facility would be unnecessary if attending an out-of-state facility, or

(3) The only in-state facilities within commuting distance are private schools where tuition costs are higher than at an out-of-state facility within commuting distance.

h. Postsecondary education up to and including a baccalaureate degree program.

(1) A participant with no postsecondary education may be approved for training resulting in a certificate of program completion or an academic degree, such as an associate or baccalaureate degree. Participants who have not completed a high school education or received a high school equivalency diploma (HSED) may be required to do so before courses leading to an associate degree or higher are approved.

(2) A participant who has a baccalaureate degree or higher is considered employable. No further training shall be approved unless the participant's physical or mental status has changed to such an extent that the past education is no longer appropriate. The participant must provide supportive evidence from either a qualified medical or mental health professional or the state rehabilitation agency.

(3) A participant who has successfully completed a postsecondary educational program that provides less than a baccalaureate degree may be approved for further training if the participant meets one of the following criteria:

1. The previous training is in an occupation that is outdated.
2. The previous training is in a field where current labor market information or emerging business trends show little or no employment opportunity.
3. The training requested is a progression in a specific career that moves a participant from entry-level positions to higher levels of pay, skill, responsibility, or authority.
4. The participant's background makes employment in the area in which the participant is trained impossible.
5. Changes in the participant's physical or mental status make the past training no longer appropriate. The participant must provide supportive evidence from a qualified medical or mental health professional or the state rehabilitation agency.

i. Prerequisite courses required by the selected training program.

j. Remedial coursework for one term when needed as determined by testing conducted by the training facility.

k. Summer school.

93.8(4) *Nonapprovable training activities.* Nonapprovable training activities shall not be included in the FIA. When an activity in which the participant is enrolled becomes nonapprovable, PROMISE JOBS shall cancel the current training plan and require the participant to renegotiate the FIA to include other activities. A form prescribed by the department shall be issued to inform the participant that the request for education is canceled. Nonapprovable activities include the following:

a. A course or training that the participant has previously completed.

b. Any course or training in a field in which the participant does not intend to seek employment after the training is completed. An exception may be made when the reason for not seeking employment is to receive further education when the education:

(1) Is a planned progression in a specific career path; and

(2) Will not lead to an advanced degree beyond a baccalaureate.

c. A training program that does not relate to the identified vocational goal.

d. Educational activities for which the participant has failed to earn the grades required for admission.

e. Education in a field in which the participant will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.

f. Out-of-state training except as allowed under paragraph 93.8(3)*"g."*

g. Training for jobs paying less than state minimum wage.

h. Training that will not be completed until after the participant leaves FIP. Training programs that exceed the known length of time during which the participant will remain eligible for FIP assistance shall be approved only if:

(1) The time remaining in the training is minimal and tuition has already been paid.

(2) There is a reasonable plan for how the program will be completed without the assistance and support from FIP or PROMISE JOBS. A reasonable plan may include but not be limited to school loans, grants, and scholarships.

93.8(5) *Training plan content.* Once a participant is approved for training, a training plan shall be developed and written into the participant's FIA. The training plan shall include:

a. Academic enrollment hours. Participants are encouraged to maintain as full an academic workload as is possible in order to complete their education in a timely manner. However, a person may choose to participate in education along with other activities such as employment, job readiness skills training, other job readiness activities, or other FIA activities.

b. Approved training plan activities.

c. The specific educational goal as defined in paragraph 93.8(1)*"a."*

d. A date by which the participant expects to complete training. This end date depends on:

(1) Time frames specified for a program as established by the educational facility.

(2) Whether the participant is attending full-time or part-time.

(3) Problems or barriers to involvement as identified in subrule 93.4(5) or 93.14(1).

e. Testing schedule. Participants enrolled in ABE or ESL programs must be able to complete training in the time determined by the testing schedule unless the PROMISE JOBS worker and, if appropriate, the participant's academic advisor or instructor agree that additional time may be allowed. Under no circumstances, however, shall more than 6 additional months be allowed. Additional time shall not be allowed if, as a result, months required to complete training would exceed 24 months for ABE or 12 months for ESL.

93.8(6) *Supportive payments.* PROMISE JOBS may provide payment for certain expenses when needed to participate in approved education and training activities as described in this subrule and in subrule 93.11(4).

a. Eligibility.

(1) Eligibility for PROMISE JOBS supportive payments for education and training begins with the date when the participant begins training under an approved plan or is removed from a waiting list as described in paragraph 93.4(4)*"e,"* whichever is later.

(2) Participant eligibility for child care assistance and transportation payments begins as described in subparagraph 93.8(6)*"a"*(1) and shall be terminated when a training plan is canceled.

(3) Each participant in postsecondary vocational training is limited to 24 fiscal months of PROMISE JOBS payment of expenses needed for participation. The 24 fiscal months do not have to be consecutive. More information about additional limits on child care expenses is contained in paragraph 93.8(6)*"b."*

(4) When more than one facility offers a particular program, payment is limited to the amount required to attend the nearest educational facility except when attending a facility that is farther away will allow the family to reach self-sufficiency earlier.

b. Child care. Child care assistance shall be provided as described in subrule 93.11(2) and 441—Chapter 170 when needed for participation in education and training activities except as described in subparagraphs 93.8(6)*"b"*(1) and (2).

(1) Child care assistance payments needed for participation in postsecondary education activities are limited to 24 fiscal months.

(2) All child care assistance payments issued for child care for participation in postsecondary education activities count toward this limit, including payments issued while the person was not a PROMISE JOBS participant, pursuant to 441—subparagraph 170.2(2)*"b"*(1).

c. Transportation. Transportation payments shall be provided as described in subrule 93.11(3) when needed for participation in educational activities unless transportation payments are available from another source. Transportation needed for participation in education activities is subject to the limits described in paragraph 93.8(6)*"a."*

(1) When a participant receives a transportation payment from another program that equals or exceeds that possible under PROMISE JOBS, transportation shall not be paid by PROMISE JOBS for any month covered by the other program.

(2) When the amount received from another program is less than that possible under PROMISE JOBS, a supplemental payment may be made as long as the combined payment does not exceed that normally paid by PROMISE JOBS.

(3) When a participant is enrolled in high school, a transportation payment shall not be allowed if transportation is available from another source, such as the school district. If child care needs or the needs of the child or the participant make it impractical or inappropriate for the participant to use transportation provided by the school district, a transportation payment may be authorized.

d. Training expenses. Participants enrolled in high school or high school equivalency completion, ABE, ESL, or postsecondary vocational training may be eligible for payment of the following expenses of training when required for participation, subject to limits in subrule 93.11(4):

(1) Enrollment fees,

(2) School application fees,

(3) Educational grant or scholarship application fees,

(4) Licensing, certification and testing fees,

(5) Travel costs required for certification or testing, and

(6) Certain practicum expenses as described in subparagraph 93.11(4)*"a"*(3).

e. Direct education costs. Participants enrolled in high school or high school equivalency completion, ABE, ESL, or short-term training programs of 29 weeks or less may also be eligible for payment for direct education costs, including:

(1) Tuition,

(2) Books,

(3) Fees including graduation,

(4) Basic school supplies,

(5) Specific supplies related to obtaining credit for a course and required of all students in a course, and

(6) Required uniforms.

f. Supplies purchased with PROMISE JOBS funds. Participants may keep any books or supplies, including tools, that were purchased with PROMISE JOBS funds.

93.8(7) *Documentation.*

a. Plan. The following information shall be documented in the participant's file.

(1) Evaluation results, pursuant to paragraph 93.8(1)*"b."*

(2) Current educational level.

(3) Justification for approval of additional postsecondary education pursuant to subrule 93.5(3).

(4) Academic probationary status pursuant to subrule 93.8(8).

(5) Justification for denial of education. Notice of Decision: Services shall be issued to the participant to deny the request for education.

b. Participation. A participant shall provide documentation of the actual hours of participation in education and homework and of grades and academic progress as described in subrule 93.10(2).

93.8(8) *Academic probation.* A participant may be placed on academic probation for at least one term, or a comparable time limit appropriate to the educational program, after which the participant shall be reevaluated for continued inclusion in education activities. This subrule does not apply to parents under the age of 18 who are attending high school completion programs.

a. Placing a participant on academic probation. The PROMISE JOBS worker may choose to place a participant on academic probation in the following circumstances:

(1) The educational evaluation completed according to paragraph 93.8(1)*"b"* identifies some factors with the participant's ability or past circumstances that could make successful completion of the training difficult but the participant's motivation is high and changes in the participant's life situation indicate a realistic probability of success.

(2) The participant was previously unable to maintain the cumulative grade point average required by a training facility in training comparable to that being requested.

(3) The participant enrolled but did not complete a previous education activity without good cause.

(4) At the end of a term, or of a comparable period applicable to the educational program, the participant is receiving less than a 2.0 grade point average or less than a higher average that is required by the specific training facility or curriculum.

b. Probation outcomes. The participant shall be removed from probation for satisfactory performance if, by the end of the established probationary period, the participant is receiving at least a 2.0 grade point average or a higher average as required by the specific training facility or curriculum.

(1) Reevaluation. If the participant is not receiving the required grade point by the end of the probationary period, the participant shall be reevaluated to determine continued eligibility for participation in education using the same type of information used to originally evaluate the likelihood of academic success as identified in paragraph 93.8(1)*"b."* Documentation shall meet the requirements as stated in subrule 93.8(7).

(2) Continued probation. Probation may be continued when reevaluation indicates that education is appropriate. The PROMISE JOBS worker may also consider continued probation when:

1. Temporary barriers such as illness or family emergencies that interfered with successful participation have been resolved.

2. Long-term barriers to successful participation have been identified and accommodations developed and implemented.

3. The counselor or the lead instructor in the educational program verifies that there is an excellent likelihood the student will raise the grade point to the acceptable level in the next term or a comparable time limit appropriate to the educational program.

(3) Cancellation of a training plan. The participant's current training plan shall be canceled if the participant has failed to maintain at least a 2.0 grade point average or a higher average required by the specific training facility or curriculum, and reevaluation indicates no mitigating circumstances as listed in subparagraph 93.8(8)*"b"*(2). When a training plan is canceled, the participant will be required to renegotiate the FIA to include either a new, more appropriate training plan or other FIA activities. Notice of Decision: Services shall be issued to the participant to inform the participant that the approval for education is canceled.

93.8(9) *LBP.* Participants in education choose an LBP through the following actions:

a. Failure to participate. The participant fails to maintain education activities or follow training plan requirements as specified in the participant's FIA, and the participant does not have good cause. Procedures in subrule 93.4(5) and 441—93.13(239B) and 441—93.14(239B) shall apply.

b. Misuse of payments. The participant misuses expense payments to the extent that the training plan is no longer achievable or knowingly provides receipts or any other written statements that have been altered, forged, or, in any way, are not authentic.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.9(239B) Other FIA activities.

93.9(1) *Parenting skills training.*

a. Parents aged 20 or older. For parents who are aged 20 or older when the FIA is signed, activities that strengthen the participant's ability to be a better parent can be considered approvable training under PROMISE JOBS and may be included in the FIA as long as the participant is active in at least one other PROMISE JOBS component. Parents aged 20 or older who do not carry out the parenting skills training described in the FIA shall be considered to have chosen the LBP unless good cause exists or family circumstances warrant renegotiation and amendment of the FIA. Procedures in subrule 93.4(5) and 441—93.13(239B) and 441—93.14(239B) shall apply.

b. Parents aged 19 or younger. Parents aged 19 or younger when the FIA is signed are required to include parenting skills training in the FIA, but may be excused from the requirement when documentation of satisfactory completion of parenting skills training is provided before the FIA is signed.

(1) Priority for orientation or assessment. In any month, PROMISE JOBS shall give priority for orientation or assessment services to parents who are already aged 19 in order to establish their responsibility for parenting classes before they are aged 20. This applies to those who are scheduled for orientation, to those who are still in assessment, and to those who have an FIA that must be renegotiated and amended.

(2) FIA requirement. The FIA shall be written or renegotiated and amended to include specific plans for parenting skills training and shall identify the training provider's name and beginning and ending dates of the training. The scheduled training may be in the future to accommodate availability of provider resources. However, it shall occur as soon as is compatible with the circumstances of the family, the other activities in the FIA, and the availability of provider resources, except as specified in paragraph 93.4(4)*"e."*

(3) Parents aged 19 or younger who are participating in a parenting skills training program at the time the FIA is signed shall be allowed to continue in that program, if they choose, as long as the provider is listed in paragraph 93.9(1)*"c"* or meets the requirements of paragraph 93.9(1)*"d"* and documentation of enrollment is provided. The time frames as described in paragraph 93.9(1)*"d"* shall be used to determine the remaining training time to be included in the FIA.

(4) Participation in other activities. Parents aged 19 or younger are not required to be participating in another PROMISE JOBS component to be eligible for parenting skills training. Other PROMISE JOBS components are included in the FIA according to policies in subrule 93.4(4).

c. Approved providers. The sources listed in this paragraph are approved providers for parenting skills training.

(1) High school departments of family and consumer sciences that offer child development, family relationships, or parenting classes and alternative high school programs for pregnant and parenting teens. Services shall be limited to a minimum of one semester and a maximum of two semesters.

(2) Community colleges, other associate-degree institutions, and baccalaureate-degree institutions that offer child development, family relationships, or parenting classes. Services shall be limited to one semester or two quarters.

(3) Area education agencies; child abuse prevention programs; child and adult food program sponsors; child care resource and referral agencies; family resource centers; maternal and child health centers; family development and self-sufficiency program grantees and other family development providers; Head Start, Head Start parent and child centers, and Early Head Start programs; Iowa State University Extension services; private nonprofit social service agencies; and young parent support and information organizations. Services shall be limited to:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
2. A maximum of 26 contact hours or six calendar months, whichever comes first.

d. Other providers of parenting skills training are approved as long as they:

(1) Have five of these six elements: child growth and development, child health and nutrition, child safety, positive discipline, relationships, and life skills.

(2) Offer training within the following time frames:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
2. A maximum of 26 contact hours or six calendar months, whichever comes first.

e. Supportive payments. For participants described in paragraphs 93.9(1)*"a"* and *"b,"* child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed for participation in parenting skills training and not available from another source.

(1) Other expenses. Payment for tuition, fees, or books and supplies shall be made only when parenting skills training is not available from a free source in the local area. PROMISE JOBS shall not pay for any expenses that are covered by student financial aid in postsecondary educational institutions as provided elsewhere in these rules.

(2) Continuation of payments. If the participant chooses to continue with the parenting skills training program beyond the designated period of participation described in paragraphs 93.9(1)*"c"* and *"d,"* PROMISE JOBS responsibility for payment of expense payments shall not extend beyond the designated period unless completion is delayed by acceptable instances for nonparticipation as stipulated in rule 441—93.14(239B) or barriers to participation in subrule 93.4(5).

f. Participation in parenting skills training. The planned duration of the parenting skills training shall be determined by agreement between the participant and the training provider within the limits described in paragraphs 93.9(1)*"c"* and *"d."*

(1) In consultation with the PROMISE JOBS worker, the participant and the provider shall design a written agreement and provide a copy to PROMISE JOBS. The agreement shall designate the period during which the mandatory parenting skills training requirement will be fulfilled. The period specified in the agreement or notice of decision shall be included in the FIA.

(2) Participants who fail to carry out this step in the FIA shall be considered to have chosen the LBP.

g. Failure to complete parenting skills training. Parents aged 19 or younger who do not include parenting skills training in the FIA or do not carry out the parenting skills training described in the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.9(2) *Family development.* Family development services are support services for PROMISE JOBS families in need of additional assistance, primarily provided by the FaDSS program operated by the department. The services are designed to promote, empower, and nurture the family to self-sufficiency and healthy reintegration into the community.

a. PROMISE JOBS may arrange for these services from entities that meet one of the following criteria wherever these are available. Family development services shall be:

(1) Provided by a FaDSS grantee; or

(2) Provided by a specialist that has been certified through the National Resource Center on Family Based Services at the University of Iowa College of Social Work or the National Family Support Certification Exam through the Institute for the Advancement of Family Support Professionals.

b. Inclusion of family development services by participants as an FIA activity is voluntary except for parents under the age of 18 who are not married and who do not live with a parent or legal guardian as described in subparagraph 93.4(4)*"c"*(4).

93.9(3) *Family planning counseling.* Referral for family planning counseling is an optional service that shall be offered to each applicant or participant. It is not a component of PROMISE JOBS.

a. The PROMISE JOBS worker shall:

(1) Discuss orally and in writing the financial implications of newly born children on the participant's family during PROMISE JOBS orientation or assessment, using a form approved by the department; and

(2) Assist the participant in locating local resources.

b. The FIA shall record participant response to the option of referral for family planning counseling. It is not acceptable for the FIA to have family planning counseling as the only step of the FIA.

c. Supportive payments. No supportive payments are allowed for family planning counseling.

d. Participation. LBP policies do not apply to participants who choose not to include family planning counseling in the FIA or who do not carry out the steps of family planning counseling.

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441—93.10(239B) Required documentation and verification.

93.10(1) *Written notification to participants.*

a. Notice of meetings, assignments, and issues. PROMISE JOBS shall notify participants in writing of all scheduled meetings, of FIA activity and work-site assignments, and of any participation issues as described in rule 441—93.13(239B). PROMISE JOBS shall also notify the participant in writing when the participant is required to provide medical documentation, verification of hours of participation, employment verification, or any other verification.

(1) PROMISE JOBS shall allow a participant ten calendar days from the date notice is mailed to appear for scheduled meetings unless the participant agrees to an appointment that is scheduled to take place in less than ten calendar days. If the tenth calendar day falls on a weekend or state holiday, the participant has until the next working day.

(2) PROMISE JOBS shall allow a participant ten calendar days from the date notice is mailed to appear for an FIA activity or work-site assignment or to provide medical documentation, employment verification, or any other verification, except as otherwise specified in subrule 93.10(2). If the tenth calendar day falls on a weekend or state holiday, the participant has until the next working day.

(3) PROMISE JOBS shall allow additional time upon request from the participant when the participant is making every effort but is unable to fulfill requirements within the established time frame.

b. Notice of decision. PROMISE JOBS shall send written notice to each participant in accordance with 441—Chapter 16 when services are approved, rejected, renewed, changed, canceled, or terminated for failure to cooperate or participate. PROMISE JOBS services are approved when the participant is assigned to begin participation in an activity as written in the FIA.

93.10(2) *Verification of participation and progress.* Hours of participation and a participant's progress in FIA activities must be documented and verified. When the participant is responsible for providing the verification, PROMISE JOBS shall notify the participant in writing as required in subrule 93.10(1).

a. FIA activities directly monitored by PROMISE JOBS. When the FIA activities are provided or directly monitored by PROMISE JOBS staff, such as job readiness skills training or structured job search, the staff shall document the participant's hours of attendance and progress in the case file.

b. FIA activities not directly monitored by PROMISE JOBS. When FIA activities are provided by a service provider other than PROMISE JOBS, the provider shall verify the participant's hours of attendance with a form prescribed by the department unless another method is required by this rule.

(1) The provider is expected to specify the participant's hours of attendance and to sign and date the Time and Attendance form.

(2) The participant is responsible for providing the signed and dated Time and Attendance form to PROMISE JOBS within ten calendar days following the end of each month, unless the provider provides the form to PROMISE JOBS within this time frame.

(3) Exception: If the participant is under age 20 and in high school or high school equivalency classes, the participant may verify the hours by completing and submitting a form prescribed by the department, Time and Attendance, monthly. The training provider does not need to sign the form.

c. Documentation of job search. The participant shall complete and provide documentation of any job search activities that cannot be verified by the PROMISE JOBS worker. The participant shall provide a form prescribed by the department within ten calendar days following the end of each month during which the participant has made a job search. The PROMISE JOBS worker shall consider the Job Search Activity Log complete if the form includes:

(1) Sufficient information to identify the employer that was contacted or the activity that was completed,

(2) The date that the contact was made or the date the activity was completed,

(3) The amount of time spent, and

(4) The participant's signature.

d. Employment verification. Participants shall verify actual hours of employment at the time that employment begins, upon FIP approval if employed at the time of application, when changes in hours occur, and no less than once every six months thereafter. Participants may use copies of pay stubs, an employer statement of earnings, or may sign a release of information prescribed by the department so that the employer may provide information directly to the PROMISE JOBS worker. Participants shall provide verification of actual hours of employment within ten calendar days of the written request from PROMISE JOBS.

e. Documentation of self-employment. At the time of the participant's FIA review, a self-employed participant shall provide documentation of actual hours worked and gross income and business expenses from the last 30 days. Data from more than 30 days may be requested if the last month is not indicative of normal business. The participant shall provide documentation within ten calendar days of the written request from PROMISE JOBS.

f. Distance learning. When a participant is involved in a distance-learning program, PROMISE JOBS will accept the documentation issued by the distance-learning institution verifying that the student participated in the sessions.

(1) Documentation may include the attendance records or log-in and log-out records available online or in an electronic format. Documentation may also be obtained through an agreement with a support agency that monitors the student's actual participation.

(2) The participant is responsible for providing the documentation within ten calendar days following the end of each month unless the institution provides the documentation to PROMISE JOBS within this time frame.

g. Failure to provide required documentation or verification. Participants who fail to provide documentation or verification as described in this subrule after written notification from PROMISE JOBS as described in subrule 93.10(1) shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.10(3) *Verification of problems or barriers.* Participants may be required to provide written verification or supporting documentation of reported problems or barriers to participation.

a. Medical documentation. A participant shall secure and provide written documentation signed by a qualified medical or mental health professional to verify a claimed illness or disability within ten calendar days of a written request by PROMISE JOBS. This time limit may be extended due to individual circumstances, such as the need to obtain an updated evaluation. Acceptable verification includes a form prescribed by the department or other statement signed by a qualified medical or mental health professional to verify the existence of an illness, disability, or limitation. If the tenth calendar day falls on a weekend or state holiday, the participant has until the next working day.

b. Other documentation. A participant shall secure and provide written documentation to verify a claimed problem or barrier to participation within ten calendar days of a written request by PROMISE

JOBS. Acceptable documentation may include a signed statement from a third party with knowledge of the problem or barrier. If the tenth calendar day falls on a weekend or state holiday, the participant has until the next working day.

c. Failure to verify problem or barrier or to provide medical documentation. Failure to provide verification of a problem or barrier or to provide medical documentation as described in subrule 93.10(3) does not directly result in the imposition of an LBP. Examples of actions that do not directly result in LBP include but are not limited to failure to provide a form prescribed by the department or other statement from a medical or mental health professional to verify the existence of an illness or disability, or a statement from a third party with knowledge about the problem or barrier.

(1) Participants who claim an inability to participate on a full-time basis due to a claimed problem or barrier and who fail to provide verification or medical documentation upon written request may be required to renegotiate the FIA to include full-time participation in FIA activities. Failure to renegotiate the FIA may result in an LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

(2) Participants who claim a problem or barrier caused their failure to participate for the full number of hours identified in their FIA and who fail to provide verification of the problem or barrier or medical documentation upon written request may not be excused for the failure to participate. If the failure is not excused, the failure will result in imposition of an LBP if the failure meets the criteria described in subrule 93.13(2).

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.11(239B) Supportive payments. In order to facilitate successful participation, PROMISE JOBS may provide payment for the expenses listed in this rule. Upon written request from PROMISE JOBS, participants shall submit a form prescribed by the department, or other acceptable estimate of costs, to initiate payments or change the amount of payment for expenses other than child care.

93.11(1) *Eligibility.* Participants are eligible for supportive payments needed for participation in activities in their FIA, subject to the limits in this chapter.

a. Applicants in an LBP who must complete significant contact with or action in regard to PROMISE JOBS for FIP eligibility to be considered as described in paragraphs 441—41.24(8)*"a"* and *"e"* are eligible for expense payments for the 20 hours of activity. However, PROMISE JOBS services and supportive payments are only available when it appears the applicant will otherwise be eligible for FIP.

b. Applicants who have received 60 months of FIP are eligible for PROMISE JOBS services and payments under the circumstances described in 441—subrule 41.30(3).

93.11(2) *Child care.* Payments for child care shall be issued through the child care assistance program as described in 441—Chapter 170.

a. Payment shall be provided for child care if:

(1) Care is needed for participation in any PROMISE JOBS activity other than orientation or assessment activities that occur before the FIA is signed,

(2) Payment is not specifically prohibited elsewhere in these rules, and

(3) Payment is not available from another source.

b. Payment shall be issued to the child care provider after the service has been received, as described in 441—subrule 170.4(7).

93.11(3) *Transportation.* Participants may receive a transportation payment for each day that transportation is needed for participation in a PROMISE JOBS activity. Transportation payments shall be determined according to the circumstances of each participant. If necessary, payments shall cover transportation for the participant and child from the participant's home to the child care provider and to the PROMISE JOBS site or activity.

a. Exclusions.

(1) A transportation payment is not available for orientation or for assessment activities that occur before the FIA is signed.

(2) A transportation payment is not available for employment. Participants who are employed shall be entitled to the earned income deduction described at 441—paragraph 41.27(2)*"a"* to cover transportation costs associated with employment.

b. Rate of payment. Payments shall not exceed the rate that the provider would charge a private individual.

(1) Public transportation. For those who use public transportation, the payment shall be based on the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment, using the rate schedules of the local transit authority to the greatest advantage, including use of weekly and monthly passes or other rate reduction opportunities.

(2) Private transportation. For participants who use a privately owned motor vehicle or who hire private transportation, the transportation payment shall be based on a formula that uses the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment multiplied by the participant's anticipated daily round-trip miles and then multiplied by the current state employee reimbursement rate.

c. Special transportation needs. Participants who require, due to a mental or physical disability, a mode of transportation other than a vehicle they operate themselves shall be eligible for payment of a supplemental transportation payment when documented actual transportation costs are greater than transportation payments provided under these rules and transportation is not available from another source.

(1) Medical evidence. To be eligible for a supplemental payment, the participant must provide medical evidence of the need for an alternate mode of transportation due to disability or incapacity. The evidence must be from a qualified medical or mental health professional, the state rehabilitation agency, or proof that the participant receives SSI or social security benefits due to disability or blindness.

(2) Payment rates. Actual costs of transportation by a public or private agency shall be allowed. Costs of transportation provided by private automobile shall be allowed as described in subparagraph 93.11(3) *"b"*(2).

d. Issuance of payments. The transportation payment shall be issued before the first scheduled day of participation in an activity. For participants in the same activity for more than one month, transportation payments shall be issued before the first day of the month of scheduled participation except as described below.

(1) Payments for the third and subsequent months of an ongoing activity shall not be authorized before receipt of time and attendance verification, as described in subrule 93.10(2), for the month before the issuance month. Example: A transportation payment for June, normally issued after May 15 to be available to the participant by June 1, will not be authorized until time and attendance verification for the month of April has been received in the PROMISE JOBS office.

(2) The amounts of payments for the third and subsequent months of an ongoing activity shall be adjusted by subtracting from normally scheduled days any number of days that represents a difference between the number of scheduled days of activity in the month before the issuance month and the number of actual days attended in that month. Example: A transportation payment is issued in May based on 16 scheduled days of participation for June. The participant attends only 14 days of the activity. When preparing to issue the August transportation allowance, the worker subtracts two days from the normally scheduled August activities to calculate the payment. If ten days of participation are scheduled, the transportation payment issued in July for August is calculated using eight days.

(3) Because adjustment for actual attendance is not possible in the last two months of an ongoing activity, transportation payments for the last two months of an ongoing activity will be subject to transportation overpayment provisions of subrule 93.12(1).

EXCEPTION: A transportation overpayment does not occur for any month in which the participant leaves the PROMISE JOBS activity in order to enter employment.

93.11(4) *Training and education expenses.* Participants shall use PROMISE JOBS payments that they receive to pay authorized expenses.

a. Classroom training. PROMISE JOBS payments for classroom training are limited as follows:

(1) Tuition payments for high school or high school equivalency completion, ABE, ESL, or short-term training programs of 29 weeks or less shall not exceed the rate charged by the Iowa community college located nearest the participant's residence that offers a course or program comparable to the one in which the participant plans to enroll. If an Iowa community college does not offer a comparable program, the

maximum tuition rate payment shall not exceed the Iowa resident rate charged by the out-of-state area school located nearest the participant's residence.

(2) A standard payment for actual costs of basic school supplies once per term shall be allowed for those participants who request it. Actual costs must be verified by receipts.

(3) A per diem payment of $10 for living costs during a practicum shall be allowed when the practicum is required by the curriculum of the training facility, would require a round-trip commuting time of three hours or more per day, and is not available closer to the participant's home. If practicum earnings or other assistance is available to meet practicum living costs, no payment shall be made.

(4) Payments may be authorized to meet the costs of travel required for certification and testing, not to exceed the transportation payment as described in subrule 93.11(3) and the current state employee reimbursement rate for meals and lodging.

(5) No payment shall be made for jewelry, pictures, rental of graduation gowns, elective courses that require expenditures for field trips or special equipment, such as photography or art supplies, or other items that are not required to complete training for a vocational goal.

b. Retroactive payments. Retroactive payments for transportation and allowable direct education costs shall be allowed only under the following conditions:

(1) If plan approval or removal from a waiting list occurs after the start of the term due to administrative delay or worker delay, payments shall be approved retroactive to the start of the term for which the plan is approved or removal from the waiting list is authorized. If the participant has already paid costs with private resources, the participant shall be reimbursed.

(2) If plan approval is delayed due to the fault of the participant, payment eligibility shall begin with the first day of the month during which the plan is approved or the month in which the participant is removed from a waiting list as described in paragraph 93.4(4)*"e,"* whichever is later. In this instance, there shall be no reimbursement for costs already paid by the participant.

c. Receipts. Participants shall furnish receipts for expenditures that they pay, except for transportation payments. Failure to provide receipts will preclude additional payments. Receipts may be requested for payments paid directly to the training provider if the PROMISE JOBS worker determines it is appropriate.

d. Payments directly to facility. PROMISE JOBS is authorized to provide payment for expenses allowable under these rules to the training facility for the educational expenses of tuition and fees and books and supplies that are provided by the facility and billed to the PROMISE JOBS participant. Payment may also be made to the participant in those situations where payment to the participant is determined to be appropriate by the PROMISE JOBS worker.

93.11(5) *Other expenses.*

a. Birth certificates. PROMISE JOBS funds shall be used to pay costs of obtaining a birth certificate when the birth certificate is needed in order for the participant to complete the workforce development registration process described in subrule 93.3(6).

b. Resources for examination. When an examination is required and other resources are not available to meet the expense of the examination, the PROMISE JOBS worker shall authorize the examination and submit a claim for payment on a form prescribed by the department.

c. Workforce Innovation and Opportunity Act. PROMISE JOBS funds may also be used to pay expenses for PROMISE JOBS participants enrolled in federal Workforce Innovation and Opportunity Act (WIOA) as amended to August 1, 2024, funded services or activities when those expenses are allowable under these rules.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.12(239B) Recovery of PROMISE JOBS expense payments. When an applicant, a participant, or a provider receives an expense payment for transportation or other supportive expenses that is greater than allowed under these rules or receives a duplicate payment of an expense payment, an overpayment is considered to have occurred and recovery is required. There are two categories of PROMISE JOBS expense payments subject to recovery: (1) transportation, and (2) other supportive expense payments.

93.12(1) Payment for transportation will be considered an overpayment subject to recovery in the following instances:

a. When the participant attends none of the scheduled days of participation in a PROMISE JOBS activity, the entire transportation payment will be considered an overpayment. Recovery of the overpayment will be initiated when it becomes clear that subsequent participation in the activity is not possible.

b. When the participant fails to attend 75 percent of the normally scheduled days of participation in either of the last two months of an ongoing PROMISE JOBS activity or in any transportation payment period of an activity that has not been used for payment adjustment as described in paragraph 93.11(3)*"d,"* an overpayment is considered to have occurred. The amount to recover will be the difference between the amount for the actual number of days attended and the amount for 75 percent of normally scheduled days.

93.12(2) The PROMISE JOBS worker shall make the referral to the department of inspections, appeals, and licensing by recording the overpayment in the overpayment recovery system.

93.12(3) The department of inspections, appeals, and licensing shall notify the participant or the provider when it is determined that an overpayment exists as described in 441—subrule 11.2(2).

a. Notification shall include the amount, date, and reason for the overpayment. Upon the participant's request, PROMISE JOBS shall provide additional information regarding the computation of the overpayment.

b. The participant may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—Chapter 2506.

93.12(4) A PROMISE JOBS overpayment shall be recovered through repayment in part or in full. Repayments received by PROMISE JOBS shall be transmitted to the department.

a. Overpayments of child care assistance issued for July 1999 and any month thereafter are subject to recovery rules of the child care assistance program set forth in rule 441—170.9(237A).

b. Reserved.

93.12(5) When a participant or a provider offers repayment in part or in full before the end of the 30-day appeal period, PROMISE JOBS or the department's local office will accept the payment. The amount of the voluntary repayment shall not be returned to the participant or provider unless the final decision on the appeal directs the department to do so. If a subsequent appeal request is received, the PROMISE JOBS unit shall notify the department of inspections, appeals, and licensing and shall not accept any further payments on the claim.

93.12(6) When a participant or a provider has been referred to the department of inspections, appeals, and licensing to initiate recovery, the department of inspections, appeals, and licensing shall use the same methods of recovery as are used for the FIP program as described in 481—Chapter 90, except that the FIP grant shall not be reduced to effect recovery without the participant's written permission.

a. When the participant requests grant reduction on a form prescribed by the department, the grant will be reduced for repayment as described in rule 441—46.25(239B).

b. The department of inspections, appeals, and licensing is authorized to take any reasonable action to effect recovery of provider overpayments, such as but not limited to informal agreements, civil action, or criminal prosecution. However, the department of inspections, appeals, and licensing shall not take any collection action on a provider overpayment that would jeopardize the participant's continued participation in the PROMISE JOBS program.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—93.13(239B) Resolution of participation issues. PROMISE JOBS participants who do not carry out the responsibilities of the FIA shall be considered to have chosen the LBP as described in 441—subrule 41.24(8). The participation issues listed in this rule are those that are important for effective functioning in the workplace or training facility and for the completion of the FIA.

93.13(1) *Notification of participation issue.* When participants appear to be choosing an LBP by not carrying out the FIA responsibilities, the PROMISE JOBS worker shall send one written reminder letter as specified in subrule 93.10(1). The written reminder letter shall:

a. Clearly identify the participation issue and the specific action needed to resolve it,

b. Clarify expectations,

c. Attempt to identify barriers to participation that should be addressed in the FIA,

d. Explain the consequences of the LBP, and

e. Offer supervisory intervention.

93.13(2) *Participation issues.* Actions that may cause participants to be considered as having chosen the LBP when the participant does not have a problem or barrier to participation as defined at paragraph 93.4(5)*"a"* or rule 441—93.14(239B) are:

a. Tardiness. Participants who, for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence, are more than 15 minutes late to a scheduled FIA activity without good cause or a barrier to participation.

b. Failure to attend scheduled activities. Participants who do not, for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence, appear for scheduled appointments, participate in assessment activities, including taking required vocational or aptitude tests, complete or provide required forms other than those described in subrule 93.10(3) or are absent from activities designated in the FIA.

c. Absence from work experience. Participants who do not, for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence, notify work experience sponsors or the PROMISE JOBS worker of an absence within one hour of the time at which they are due to appear.

d. Disruptive behavior. Participants who exhibit disruptive behavior for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence. "Disruptive behavior" means the participant hinders the performance of other participants or staff, refuses to follow instructions, uses abusive language, or is under the influence of alcohol or drugs.

e. Unsatisfactory performance or participation. Participants whose performance or participation in an FIA activity continues to be unsatisfactory after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1).

f. Physical threats. Participants who make physical threats to other participants or staff and have not provided written documentation from a doctor, licensed psychologist, probation officer, or law enforcement official after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1).

(1) "Physical threat" means having a dangerous weapon in one's possession and either threatening with or using the weapon or committing assault.

(2) The documentation must verify that the act was caused by either a temporary problem or a serious problem or barrier that needs to be included in the FIA. The documentation must also provide reasonable assurance that the threatening behavior will not occur again.

g. Accepting work experience assignments. Participants who do not accept work experience assignments when the work experience is part of the FIA and do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1).

h. Work experience interviews. Participants who do not appear for work experience interviews for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence.

i. Employment and other work activity issues. Participants who do not follow up on job referrals, who refuse offers of employment or other work activity, who reduce hours of employment or other work activity, who terminate employment or other work activity, or who are discharged from employment or other work activity.

(1) At the time of the occurrence, PROMISE JOBS shall send a letter to the participant. The letter shall give the participant an opportunity to resolve the issue by accepting a previously refused employment offer if available, returning to previously terminated employment, if available, obtaining comparable employment, or demonstrating a problem or barrier that caused the failure.

(2) Reserved.

j. Failure to secure child care. Participants who do not secure adequate child care when registered or licensed facilities are available after PROMISE JOBS sends one written reminder as described in subrule 93.13(1) and when PROMISE JOBS has provided the participant with resources for locating adequate child care.

k. Inappropriate use of funds. Participants for whom child care, transportation, or educational services become unavailable as a result of failure to use PROMISE JOBS funds or child care assistance funds to pay the provider or failure to provide required receipts and who do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1).

l. Failure to follow training plan. Education participants who do not follow the requirements of a training plan in the FIA as described in rule 441—93.8(239B).

m. Failure to renegotiate the FIA. When a participant fails to respond to the PROMISE JOBS worker's request to renegotiate the FIA because the participant has not attained self-sufficiency by the date established in the FIA, after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1), an LBP shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the FIA.

93.13(3) *Choosing an LBP.*

a. Before determining that a participant has chosen the LBP due to a potential participation issue, the PROMISE JOBS worker shall make every effort to negotiate a solution and determine:

(1) Whether the participant has a problem that provides good cause for the participation issue as described in rule 441—93.14(239B). If so, the participant shall be encouraged to take actions to fulfill the FIA.

(2) Whether participant circumstances indicate that a barrier to participation exists as described in subrule 93.4(5). If so, the FIA shall be negotiated to address the barrier.

b. The participant may be considered to have chosen the LBP when all of the following occur:

(1) The participant is notified of a participation issue as described in subrule 93.13(1);

(2) The participant does not resolve the participation issue;

(3) The participant does not present acceptable evidence of a problem providing good cause for the issue as described in rule 441—93.14(239B); and

(4) The participant does not present acceptable evidence of a barrier to participation as described in subrule 93.4(5) or fails to renegotiate the FIA to address the identified barrier.

c. If the resolution process does not lead to fulfillment of the FIA, the case shall be referred for review.

(1) The department retains control and oversees review procedures even when another agency is contracted with to provide PROMISE JOBS services.

(2) Reserved.

d. If the above steps do not lead to fulfillment of the FIA, the FIP participant is considered to have chosen the LBP and the notice of decision will be initiated. The notice of decision will inform the participant of:

(1) The action needed to reconsider the LBP as described in 441—subparagraph 41.24(8)*"d"*(1) and 41.24(8)*"e"*(3).

(2) Appeal rights under the LBP are described in rule 441—93.15(239B).

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.14(239B) Problems that may provide good cause for participation issues.

93.14(1) *Problems leading to less than full participation.* Problems affecting participation shall be considered to be of a temporary or incidental nature when the participation can easily be resumed. The following problems may provide good cause for participation of less than the full number of hours identified in the FIA. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described in subrule 93.10(3):

a. Illness of the participant. When a participant is ill more than three consecutive days or if illness is habitual, the PROMISE JOBS worker may require medical documentation of the illness.

b. Illness of family member. When a participant is required in the home due to illness of another family member, the PROMISE JOBS worker may require medical documentation.

c. Family emergency, using reasonable standards of an employer.

d. Bad weather, using reasonable standards of an employer.

e. Absence or tardiness due to participant's or spouse's job interview. When possible, the participant shall provide notice of the interview at least 24 hours in advance including the name and address of the employer conducting the interview. When 24-hour notice is not possible, notice must be given as soon as possible and before the interview.

f. Leave due to the birth of a child. When a child is born after referral, necessary absence shall be determined in accordance with the Family Leave Act of 1993 as amended to August 1, 2024.

g. Court appearance.

h. Attendance at school functions of the participant's children or children in the participant's household.

i. Attendance at required meetings with the department or PROMISE JOBS.

j. Absence due to up to ten holidays per year.

(1) The participant must normally have been scheduled to work, or participate in an unpaid work activity on the given day and the work site or facility is closed due to a holiday, or open but the participant is allowed to take the participant's normally scheduled hours off on a different day.

(2) The holidays included are New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Fourth of July, Labor Day, Veterans Day, Thanksgiving, the day after Thanksgiving, and Christmas.

93.14(2) *Problems leading to refusing or quitting a job or limiting or reducing hours.* The following problems may provide good cause for participation issues of refusing or quitting a job or limiting or reducing hours. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described in subrule 93.10(3):

a. Required travel time from home to the job or available work experience or unpaid community service site exceeds one hour each way. This includes additional travel time necessary to take a child to a child care provider.

b. Except as described in 441—subrule 41.25(5), work offered is at a site subject to a strike or lockout, unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A, commonly known as the Taft-Hartley Act) as amended to August 1, 2024, or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160) as amended to August 1, 2024.

c. The work site violates applicable state or federal health and safety standards or workers' compensation insurance is not provided.

d. The job is contrary to the participant's religious or ethical beliefs.

e. The participant is required to join, resign from or refrain from joining a legitimate labor organization.

f. Work requirements are beyond the mental or physical capabilities as documented by medical evidence or other reliable sources.

g. Discrimination by an employer based on age, race, sex, color, disability, religion, national origin or political beliefs.

h. Work demands or conditions render continued employment unreasonable, such as working without being paid on schedule.

i. Circumstances beyond the control of the participant, such as interruption of regular mail delivery or other disruptions of services.

j. Employment change or termination is part of the FIA.

k. Job does not pay at least the minimum amount customary for the same work in the community.

l. The participant terminates employment in order to take a better-paying job, even though hours of the new job may be less than those in the previous job.

m. The employment would result in the family of the participant experiencing a net loss of cash income. Net loss of cash income results if the family's gross income less necessary work-related expenses is less than the cash assistance the person was receiving at the time the offer of employment is made. Gross income includes, but is not limited to, earnings, unearned income, and cash assistance. Gross income does not include SNAP benefits and in-kind income.

n. The employment changes substantially from the terms of hire, such as a change in work hours or work shift or a decrease in pay rate.

93.14(3) *Other problems.* The PROMISE JOBS worker may identify circumstances that could negatively impact the participant's achievement of self-sufficiency that are not described in subrule 93.14(1) or 93.14(2). When this occurs, the case shall be referred to the department for a determination as to whether the problems are acceptable reasons for:

a. Not participating,

b. Refusing or quitting a job, or

c. Discharge from employment due to misconduct as described in paragraph 93.13(2)*"i."*

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441—93.15(239B) Right of appeal. In accordance with 441—Chapter 2506, each applicant or participant is entitled to appeal and to be granted a hearing over disputes regarding: (1) services being received; (2) services that have been requested and denied, reduced, canceled, or inadequately provided; and (3) overpayments of PROMISE JOBS expense payments.

93.15(1) *Informal resolution process.* When there is a disagreement between the participant and the immediate PROMISE JOBS worker regarding the participant's FIA or participation in PROMISE JOBS components, the participant may request an interview with the supervisor and a decision on the dispute. The supervisor shall schedule a face-to-face interview with the participant within 7 days and issue a decision in writing within 14 days of the participant's request.

93.15(2) *Appeal on the content of the FIA.* A participant shall have the right to appeal the content of the FIA when the informal resolution process described in subrule 93.15(1) does not resolve a disagreement between the participant and the PROMISE JOBS worker.

93.15(3) *Appeal of an alleged violation of PROMISE JOBS program policy.* Participants shall have the right to file a written appeal concerning any alleged violation of a PROMISE JOBS program policy that is imposed as a condition of participation. PROMISE JOBS shall provide the participant with written documentation that specifies the participation requirement in dispute.

93.15(4) *Appeal rights under the LBP.* A participant has the right to appeal the establishment of the LBP only once, at the time the department issues the timely and adequate notice that establishes the LBP. However, when the reason for the appeal is based on incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

93.15(5) *Recovery of assistance when a new LBP is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new LBP period is established. A new LBP period shall be established when the department is affirmed in a timely appeal of the establishment of the LBP. All of the following conditions shall exist:

a. The appeal is filed either:

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

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

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

c. The department's action is affirmed.

93.15(6) *Request for a hearing on work conditions or availability of workers' compensation coverage.* A participant who is enrolled in the PROMISE JOBS program may request a hearing if dissatisfied with working conditions, the availability of workers' compensation coverage or the wage rate used in determining hours of work experience program participation.

a. When any involved party is dissatisfied with the department's final decision, the dissatisfied party shall be informed of the right to appeal the issue to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, within 20 days of receipt of the decision. The department may assist with the appeal upon request.

b. For the purposes of this rule, the department's final decision shall be considered received the second day after the date that the written decision was mailed, unless the intended recipient can

demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery day.

c. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review provided in Iowa Code chapter 17A or as described in 441—Chapter 2506.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—93.16(239B) Resolution of an LBP.

93.16(1) *Resolution process for a first LBP.* For participants who choose a first LBP, the notice of decision shall inform the participant of the action needed to reconsider the LBP as described in 441—subparagraph 41.24(8)*"d"*(1).

a. The notice of decision establishing a first LBP will inform the FIP participant that the participant may reconsider at any time from the date timely and adequate notice is issued establishing the LBP. The notice of decision will inform the participant that the participant shall contact the department or appropriate PROMISE JOBS office to reconsider the LBP.

b. When the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to begin or resume development of the FIA as described elsewhere in these rules.

c. When the FIA is signed, the PROMISE JOBS worker shall notify the department and the LBP shall be terminated. FIP benefits shall be effective as described in 441—subparagraph 41.24(8)*"d"*(1).

93.16(2) *Resolution process for a subsequent LBP.* The notice of decision establishing a subsequent LBP will inform the FIP participant of the six-month ineligibility period and that the participant may reconsider at any time following the six-month ineligibility period. To reconsider, the participant must complete significant contact with or action in regard to the PROMISE JOBS program as described in 441—subparagraph 41.24(8)*"e"*(3).

a. When the six-month ineligibility period ends and the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to sign a new or updated FIA and to begin significant action as described in 441—subparagraph 41.24(8)*"e"*(3).

b. When the FIA is signed and the participant has satisfactorily completed the significant action, the PROMISE JOBS worker shall notify the department and the LBP shall be terminated. FIP benefits shall be effective as described in 441—subparagraph 41.24(8)*"e"*(4).

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25]

441—93.17(239B) Worker displacement grievance procedure. The PROMISE JOBS program shall provide a grievance procedure to address and resolve public complaints regarding the displacement of regular workers with program participants in a work experience placement.

93.17(1) The procedure shall provide that:

a. Complaints must be filed in writing and received by the PROMISE JOBS service provider within one year of the alleged violation.

b. A representative of the PROMISE JOBS service provider must schedule a face-to-face interview with the complainant within 7 days of the date the complaint is filed, to provide the opportunity for informal resolution of the complaint.

c. Written notice of the location, date and time of the face-to-face interview must be provided.

d. An opportunity must be provided to present evidence at the face-to-face interview.

e. The representative of the PROMISE JOBS service provider shall issue a decision in writing within 14 days of the date a complaint is filed.

f. A written explanation must be provided to all involved parties of the right to file a written appeal, according to 441—Chapter 2506, if the opportunity for informal resolution is declined, if a party receives an adverse decision from the PROMISE JOBS service provider, or if there is no decision within the 14-day period.

(1) To be considered, an appeal must be filed with the department within 10 days of the mailing date of the adverse decision or within 24 days of the date a complaint is filed.

(2) An appeal hearing will not be granted until informal resolution procedures have been exhausted, unless a decision has not been issued within 24 days of the complaint filing date.

93.17(2) The department will issue a final decision within 90 days of the date the complaint was filed with the PROMISE JOBS service provider.

93.17(3) Any dissatisfied party will be informed of the right to appeal the decision of the department to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, within 20 days of the receipt of the department's final decision.

a. For the purposes of this rule, the department's final decision will be considered received the second day after the date that the written decision was mailed unless the intended recipient can demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery date.

b. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review as provided in Iowa Code chapter 17A or as described in 441—Chapter 2506.

93.17(4) Upon notice of a complaint or grievance, the PROMISE JOBS office must provide the complaining party with a copy of the grievance procedures, notification of the right to file a formal complaint and instruction on how to file a complaint.

93.17(5) Upon filing a complaint, and at each stage thereafter, each complainant must be notified in writing of the next step in the complaint procedure.

93.17(6) The identity of any person who has furnished information relating to, or assisting in, an investigation of a possible violation must be kept confidential to the extent possible, consistent with due process and a fair determination of the issues.

93.17(7) All employers who participate in the PROMISE JOBS program shall provide assurances that all regular employees are aware of this grievance procedure.

[**ARC 9281C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 239B.17 through 239B.22.

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TITLE X
SUPPORT RECOVERY

CHAPTER 94
CHILD SUPPORT PROMOTING OPPORTUNITIES FOR PARENTS PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—94.1(252B) Definitions.

"Assigned support arrearages" means support arrearages for which all rights have been and will remain assigned to the state of Iowa.

"Designated provider" means any project approved in whole or in part by child support services and approved by the department to assist parents in overcoming the barriers that interfere with fulfilling obligations to their children. Each project must have a project plan approved by the department.

"Incentives" means satisfaction of support obligations and bypass of select enforcement tools, such as license sanction, administrative levy, and contempt.

"Participant" means a person who receives services or incentives through a project.

"Periodic support payment" means the total support payment due in each time period in accordance with the established support obligation. If no current support is due, the periodic support payment is equivalent to the last current support amount as would be ordered under 441—Chapter 98.

"Project plan" means the written policies, procedures, eligibility criteria and other components as described in subrule 94.3(2).

[**ARC 8960C**, IAB 2/19/25, effective 4/1/25]

441—94.2(252B) Purpose and incentives. Child support services may partner with community providers and resources to offer incentives to participants to assist in overcoming barriers to fulfilling their obligations and to encourage participants' completion of the project. The available incentives include the following:

94.2(1) *Satisfaction of the assigned support arrearages.*

a. A participant will be granted a partial satisfaction of the assigned support arrearages that are and that will remain owed by that participant to the state after that participant's successful completion of the project and payment of that participant's periodic support payments. Satisfactions granted under this subrule will apply only to those cases for which periodic support payment is credited.

b. Each satisfaction will be an amount equal to a percentage of that participant's support arrearages, which are and which will remain owed to the state, according to the following schedule:

(1) A one-time satisfaction after six consecutive months from the participant's completion of the project. The amount of satisfaction will be a percentage based on the amount of periodic support paid on all qualifying cases as follows:

1. When 100 percent of the periodic support is paid, the satisfaction amount will equal 50 percent of the amount owed to the state.
2. When 99 to 80 percent of the periodic support is paid, the satisfaction amount will equal 40 percent of the amount owed to the state.
3. When 79 to 60 percent of the periodic support is paid, the satisfaction amount will equal 30 percent of the amount owed to the state.
4. When 59 to 40 percent of the periodic support is paid, the satisfaction amount will equal 20 percent of the amount owed to the state.
5. When 39 to 20 percent of the periodic support is paid, the satisfaction amount will equal 10 percent of the amount owed to the state.
6. When 19 to 0 percent of the periodic support is paid, the satisfaction amount will equal 0 percent of the amount owed to the state.

(2) A one-time satisfaction after 12 consecutive months from the participant's completion of the project. The amount of satisfaction will be a percentage based on the amount of periodic support paid on all qualifying cases as follows:

1. When 100 percent of the periodic support is paid, the satisfaction amount will equal 100 percent of the amount owed to the state.

2. When 99 to 80 percent of the periodic support is paid, the satisfaction amount will equal 80 percent of the amount owed to the state.

3. When 79 to 60 percent of the periodic support is paid, the satisfaction amount will equal 60 percent of the amount owed to the state.

4. When 59 to 40 percent of the periodic support is paid, the satisfaction amount will equal 40 percent of the amount owed to the state.

5. When 39 to 20 percent of the periodic support is paid, the satisfaction amount will equal 20 percent of the amount owed to the state.

6. When 19 to 0 percent of the periodic support is paid, the satisfaction amount will equal 0 percent of the amount owed to the state.

c. A participant subject to an income withholding order will be eligible for the satisfaction in this subrule if the sole reason for ineligibility is a disparity between the schedules of the participant's pay date and the scheduled date the payment is due.

d. A participant will be eligible for a satisfaction under this subrule if the participant is no longer a participant but has continued to pay the participant's periodic support payment without interruption.

94.2(2) *Enforcement processes.* Child support services may bypass select enforcement tools if the participant is actively in the project.

[**ARC 8960C**, IAB 2/19/25, effective 4/1/25]

441—94.3(252B) Establishment of designated providers. Child support services may initiate a request for project plans to become designated providers.

94.3(1) *Contents of a request for project plans.* The request for project plans will contain the requirements for contents of the project plan and any other parameter for the specific project being advertised. The request will also contain a deadline by which project plans must be submitted to the department.

94.3(2) *Contents of project plans.* Each project will have and maintain a project plan. At a minimum, the project plan will contain or address the following:

a. The applicant's experience and success at integrating collaborations and services essential to the project.

b. The geographic area to be served and community need for projected services.

c. The projected number of participants to be served and the criteria to be used for the selection and termination of participants.

d. The specific parenting curriculum to be used. The curriculum must be well-established, have a track record of use and be field-tested.

e. A description of the components of the curriculum. The components of the curriculum should include personal development, responsible parenting, parenting skills, financial responsibilities, communication skills, and domestic violence prevention.

f. The schedule, location, hours of instruction and format for administering the curriculum.

g. A description of the organization and identification of staff responsible for delivering the curriculum. The staff should have experience in group facilitation and be certified trainers in the curriculum.

h. A clear explanation of how the curriculum and services will be monitored and evaluated, including how the participants will be tracked and what data will be collected.

i. Project duration.

94.3(3) *Amendments to project plan.* Participants may submit proposed amendments to their project plan in writing to the department. The department will have the option, after review, of approving or disapproving all proposed amendments to the project plan.

[**ARC 8960C**, IAB 2/19/25, effective 4/1/25]

441—94.4(252B) Selection of designated providers. The department will have sole authority to select designated providers. The department will select which of the project plans received on or before the

deadline date will be granted the status of designated providers. The selection of designated providers will be based upon the content of the project plan and must include the following:

1. Applicant's experience.
2. Geographic area selected and community need for the project.
3. Participants to be served and criteria to be used to select participants and terminate their participation.
4. The parenting curriculum to be used.
5. A description of the components of the curriculum.
6. The schedule, location, hours of instruction and format for administering the curriculum.
7. A description of the organization and identification of staff.
8. An explanation of monitoring and evaluation.
9. Project duration.

[**ARC 8960C**, IAB 2/19/25, effective 4/1/25]

441—94.5(252B) Termination of designated providers. The department may immediately terminate child support services' participation with a designated provider if the designated provider is not fulfilling the terms of its project plan or the designated provider is not fulfilling the terms for child support services' participation in the project plan.

[**ARC 8960C**, IAB 2/19/25, effective 4/1/25]

441—94.6(252B) Reports and records.

94.6(1) *Reports.* Designated providers established under these rules must report to child support services at least monthly unless otherwise mandated by the project plan. These reports must include the following:

a. Attendance documentation with the names of participants served.
b. Signed voluntary consent of participants seeking incentives.
c. Certification of participants completing the curriculum.
d. Other information as specified in the project plan.

94.6(2) *Records retention.* Designated providers must retain all records as necessary to meet the requirements of these rules.

[**ARC 8960C**, IAB 2/19/25, effective 4/1/25]

441—94.7(252B) Receipt of incentives. Participants receiving incentives under these rules may continue to receive the incentives after the termination of these rules or after they are no longer participants only under subrule 94.2(1). Subrule 94.2(1) will apply to a participant or former participant for the full time period allowed in that subrule.

[**ARC 8960C**, IAB 2/19/25, effective 4/1/25]

441—94.8(17A) Right of appeal. Child support services actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[**ARC 8960C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 252B.3(5) and chapter 17A.

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CHAPTER 95
CHILD SUPPORT SERVICES
[Prior to 7/1/83, Social Services[770] Ch 95]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—95.1(252B) Definitions.

"Caretaker" means a custodial parent, relative, or guardian whose needs are included in an assistance grant paid according to Iowa Code chapter 239B, who is receiving this assistance on behalf of a dependent child, or who is a recipient of nonassistance child support services.

"Current support" means those payments received in the amount, manner, and frequency as specified by an order for support and that are paid to the clerk of the district court, the public agency designated as the distributor of support payments as in interstate cases, or another designated agency. Payments to persons other than the clerk of the district court or other designated agency do not satisfy the definition of support pursuant to Iowa Code section 598.22.

"Date of collection" means the date that a support payment is received by the department or the legal entity of any state or political subdivision actually making the collection, or the date that a support payment is withheld from the income of a responsible person by an employer or other income provider, whichever is earlier.

"Dependent child" means a person who meets the eligibility criteria established in Iowa Code chapter 234 or 239B, and whose support is required by Iowa Code chapter 234, 239B, 252A, 252C, 252F, 252H, 252K, 598 or 600B, and any other comparable chapter.

"Obligee" means any person or entity entitled to child support or medical support for a child.

"Obligor" means a parent, relative, or guardian or any other designated person who is legally liable for the support of a child or a child's caretaker.

"Prepayment" means payment toward an ongoing support obligation when the payment exceeds the current support obligation and amounts due for past months are fully paid.

"Public assistance" means assistance provided according to Iowa Code chapter 239B or 249A, the cost of foster care provided by the department according to Iowa Code chapter 234, or assistance provided under comparable laws of other states.

"Responsible person" means a parent, relative, or guardian or any other designated person who is or may be declared to be legally liable for the support of a child or a child's caretaker. For the purposes of calculating a support obligation pursuant to the mandatory child support guidelines prescribed by the Iowa Supreme Court in accordance with Iowa Code section 598.21B, this means the person from whom support is sought.

"Support" means child support or medical support or both for purposes of establishing, modifying, or enforcing orders and means spousal support for purposes of enforcing an order.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.2(252B) Child support eligibility and services.

95.2(1) *Public assistance cases.* Child support services will provide paternity establishment and support establishment, modification and enforcement services as appropriate, under federal and state laws and rules for children and families referred to child support services who have applied for or are receiving public assistance. Referrals under this subrule may be made by the family investment program (FIP), the Medicaid program, the foster care program, or agencies of other states providing child support services under Title IV-D of the Social Security Act as amended to August 1, 2024, for recipients of public assistance.

95.2(2) *Nonpublic assistance cases.* The same services provided by child support services for public assistance cases will also be made available to any person not otherwise eligible for public assistance. A person who is not on public assistance requesting services under this chapter will complete and submit to child support services a form prescribed by the department, or an electronic version of such application, for each parent from whom the person is seeking support. The person requesting services has the option to seek

support from one or both of a child's parents. Child support services will not require an application from the following:

a. Persons not receiving public assistance for whom an agency of another state providing Title IV-D child support services has requested services.

b. Persons for whom a foreign country as defined in Iowa Code chapter 252K has requested services.

c. Persons who are eligible for continued services upon termination of assistance under the family investment program or Medicaid.

95.2(3) *Services available.* Except as provided by separate rule, child support services will provide the same services to persons receiving public assistance and persons not receiving public assistance. Child support services will determine the appropriate enforcement procedure to be used. The services are limited to the establishment of paternity, the establishment and enforcement of child support obligations and medical support obligations, and the enforcement of spousal support orders if the spouse is the custodial parent of a child for whom the department is enforcing a child support or medical support order.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.3(252B) Crediting of current and delinquent support. The amounts received as support from the obligor will be credited as the required support obligation for the month in which they are collected. Any excess will be credited as delinquent payments, will be applied to the immediately preceding month, and then will be applied to the next immediately preceding month until all excess has been applied. Funds received as a result of federal tax offsets will be credited according to rule 441—98.30(252B).

The date of collection will be determined as follows:

95.3(1) *Payments from income withholding.* Payments collected as the result of income withholding are considered collected in the month in which the income was withheld by the income provider. The date of collection will be the date on which the income was withheld.

a. For the purpose of reporting the date the income was withheld, the department will notify income providers of the requirement to report the date income was withheld and will provide a form prescribed by the department to those income providers who manually remit payments. When reported on this form or through other electronic means or multiple account listings, the date of collection will be used to determine support distributions. When the date of collection is not reported, support distributions will initially be issued based on the date of the check. If proof of the date of collection is subsequently provided, any additional payments due the recipient will be issued.

b. When the collection services center (CSC) is notified or otherwise becomes aware that a payment received from an income provider pursuant to 441—Chapter 98 includes payment amounts such as vacation pay or severance pay, these amounts are considered irrevocably withheld in the months documented by the income provider. When the income provider does not document the months for which the sums are withheld, the amounts will initially be distributed based on the date of the check. If documentation is subsequently provided, any additional payments due the recipient will be issued.

95.3(2) *Payments from state or political subdivisions.* Payments collected from any state or political subdivision are considered collected in the same month the payments were actually received by that legal entity or the month withheld by an income provider, whichever is earlier. Any state or political subdivision transmitting payments to the department will be responsible for reporting the date the payments were collected. When the date of collection is not reported, support distributions will be initially issued based on the date of the state's or political subdivision's check. If proof of the date of collection is subsequently provided, any additional payments due the recipient will be issued.

95.3(3) *Additional payments.* An additional payment in the month that is received within five calendar days prior to the end of the month will be considered collected in the next month if:

a. CSC is notified or otherwise becomes aware that the payment is for the next month, and

b. Support for the current month is fully paid.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.4(252B) Prepayment of support. Prepayment that is due to the obligee will be sent to the obligee upon receipt by the department and will be credited as payment of future months' support. Prepayment that is due the state will be distributed as if it were received in the month when due. Support is prepaid when

amounts have been collected that fully satisfy the ongoing support obligation for the current month and all past months.
[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.5(252B) Lump sum settlement.

95.5(1) Any lump sum settlement of child support involving an assignment of child support payments will be negotiated in conjunction with child support services. Child support services will be responsible for the determination of the amount due the department, including any accrued interest on the support debt computed in accordance with Iowa Code section 535.3 for court judgments. This determination of the amount due will be made in accordance with 45 CFR Section 302.51 (as amended to August 1, 2024). The department may waive collection of the accrued interest when negotiating a lump sum settlement of a support debt if the waiver will facilitate the collection of the support debt.

95.5(2) Child support services is responsible for the determination of the department's entitlement to all or any of the lump sum payment in a paternity action.
[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.6(17A) Appeals. Nonreceipt of support collected by the department that is to be paid to the obligee may be appealed pursuant to the procedures provided in this rule if the obligee claims that the payment was credited to the incorrect month in accordance with subrules 95.3(1), 95.3(2), and 95.3(3).

95.6(1) *Contact.* Obligees who believe they have not received all or part of a support payment to which they are entitled in accordance with subrules 95.3(1), 95.3(2), and 95.3(3) must first contact a customer service representative and indicate that they have not received the payment.

a. An obligee may contact a customer service representative by telephone or in writing.

b. The department will acknowledge this contact in writing, indicating the months at issue.

95.6(2) *Written decision.* Within 30 days of the contact, the department will issue a written decision on all contested support distributions based on the date of collection.

95.6(3) *Initiation of appeal.* If the department denies some or all support payments that are claimed based on the date of collection, the obligee may initiate an administrative appeal.

a. To initiate an administrative appeal, the obligee will make a written request to child support services indicating an intent to appeal.

b. The time limit for initiating an administrative appeal is governed by 441—subrule 2506.4(7). The time limit provided in 441—subrule 2506.4(7) will start with the date that a written decision as required by subrule 95.6(2) is issued.

c. If no written decision has been issued after 30 days, the obligee may appeal the failure to issue a written decision. The appeal may be initiated at any time after 30 days and before a written decision is issued.

95.6(4) *Limitation of appeals.* Appeals will be limited to claims based on child support received by the department during the nine-month period before the month in which the appeal is initiated.

95.6(5) *Appeal process.* Except as specifically provided in this rule, administrative appeals are governed by 441—Chapter 2506.

95.6(6) *Appeal issue.* The issue in appeals held pursuant to these procedures will be limited to the obligee's entitlement to a support payment that has been collected by the department.
[**ARC 8961C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—95.7(252B) Termination of services.

95.7(1) *Case closure criteria.*

a. Child support services may terminate services when a case meets at least one of the following case closure criteria and child support services maintains supporting documentation for the case closure decision in the record:

(1) There is no ongoing support obligation and arrearages are under $500 or unenforceable under state law.

(2) The noncustodial parent or alleged father is deceased and no further action, including a levy against the estate, can be taken.

(3) The noncustodial parent is living with the minor child as the primary caregiver, the custodial parent is deceased, and there is no assignment to the state of support or of arrearages that accrued under the support order.

(4) Child support services cannot establish paternity because:

1. The child is at least 18 years old and the statute of limitations bars an action to establish paternity;

2. A genetic test or a court or administrative process has excluded the alleged father and no other alleged father can be identified;

3. Child support services has determined that it would not be in the best interest of the child to establish paternity in a case that involves incest or rape or a case in which legal proceedings for adoption are pending; or

4. The identity of the biological father is unknown and cannot be identified after diligent efforts, including at least one interview by child support services with the recipient of services.

(5) The noncustodial parent's location is unknown and child support services has made diligent efforts to locate the noncustodial parent using multiple sources, in accordance with regulations in 45 CFR Section 303.3 (as amended to August 1, 2024), all of which have been unsuccessful, within the applicable time frame:

1. Over a three-year period when there is sufficient information to initiate an automated locate effort.

2. Over a one-year period when there is not sufficient information to initiate an automated locate effort.

(6) Child support services has determined that, throughout the duration of the child's minority (or after the child has reached the age of majority), the noncustodial parent cannot pay support and shows no evidence of support potential because the parent has been institutionalized in a psychiatric facility, is incarcerated, or has a medically verified total and permanent disability. Child support services must also determine that the noncustodial parent has no income or assets available above the subsistence level that could be levied or attached for support.

(7) The noncustodial parent's sole income is from supplemental security income (SSI) payments.

(8) The noncustodial parent is a citizen of and lives in a foreign country, does not work for the federal government or a company with headquarters or offices in the United States, and has no reachable domestic income or assets and there is no federal or state treaty or reciprocity with the country.

(9) In a case involving child support services to a person who is not a recipient of public assistance, child support services has provided location-only services.

(10) Child support services has received a written or verbal request from the recipient of services to close the case and there is no assignment to the state of support or of arrearages that accrued under the support order.

(11) In a case involving child support services to a recipient of public assistance, there has been a finding of good cause or other exception in a public assistance case as specified in 441—subrules 41.3(6) through 41.6(10) and 75.14(3), including a determination that support enforcement may not proceed without risk or harm to the child or caretaker relative.

(12) In a case involving child support services to a person who is not a recipient of public assistance or who is a recipient of public assistance receiving Medicaid only, child support services has received information that the address in child support services' record is no longer current and child support services is unable to contact or otherwise locate the recipient within 60 days following receipt of this information despite a good-faith effort to contact the recipient through at least two different methods.

(13) In a case involving child support services to a person who is not a recipient of public assistance or who is a recipient of public assistance receiving Medicaid only, the recipient of services has failed to cooperate with child support services, which documented the circumstances of the noncooperation, and an action by the recipient of services is essential for the next step in providing services. More information is contained in rule 441—95.11(252B).

(14) Child support services documents failure by the initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), to take an action that is essential for the next step in providing services.

(15) The initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), has notified child support services that the initiating agency has closed its case.

(16) The initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), has notified child support services that its intergovernmental services are no longer needed.

(17) Another assistance program, including IV-A, IV-E, SNAP, and Medicaid, has referred to child support services a case for which it is inappropriate to establish, enforce, or continue to enforce a child support order and the custodial or noncustodial parent has not applied for child support services.

(18) The case meets any other basis for case closure based upon federal law.

b. Child support services may terminate services when no support or arrearages that accrued under the support order are assigned to the state and the recipient of services requested child support services to close the case to allow the tribal IV-D agency to start providing services under that program.

c. Child support services will close a case and maintain supporting documentation for the case closure decision when the following criteria have been met:

(1) Child support services is notified that the child is eligible for health care services from the Indian Health Service (IHS); and

1. The IV-D case was opened because of a Medicaid referral based solely upon health care services, including the Purchased/Referred Care Program, provided through an Indian health program as defined in 25 U.S.C. Section 1603(12) (as amended to August 1, 2024); and

2. The recipient of services requests that child support services close the case.

(2) Child support services receives instructions for case closure from an initiating agency as defined under 45 CFR Section 301.1 (as amended to August 1, 2024). Within ten working days, child support services will stop the income withholding order or notice and close the intergovernmental IV-D case.

95.7(2) *Case closure notifications.* In cases meeting one of the criteria of subrule 95.7(1), except subparagraph 95.7(1)*"a"*(9), 95.7(1)*"a"*(10), or 95.7(1)*"a"*(11), child support services will send notification of its intent to close the case to the recipient of services or the initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), in writing 60 calendar days before case closure. The notice will be sent to the recipient of services or the state requesting services at the last-known address stating the reason for denying or terminating services, the effective date, and an explanation of the right to request a hearing according to 441—Chapter 2506. Closure of the case following notification is subject to the following:

a. If, in response to the notice, the recipient of services or the initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), supplies information that could lead to the establishment of paternity or a support order or enforcement of an order, the case will be kept open.

b. If the case is to be closed because child support services was unable to contact the recipient of services, as provided in subparagraph 95.7(1)*"a"*(12), the case shall be kept open if contact is reestablished with the recipient of services before the effective date of the closure.

c. The recipient of services may request to have child support services reopen the case at a later date if there is a change in circumstances that could lead to the establishment of paternity or a support order or enforcement of an order by completing a new application and paying any applicable fee.

d. If the recipient of services specifically authorizes consent for electronic notifications, child support services may elect to notify the recipient of services electronically of child support services' intent to close the case. Child support services must maintain documentation of the recipient's consent in the case record.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—95.8(252B) Child support services attorney.

95.8(1) *State's representative.* An assistant attorney general, assistant county attorney, or independent contract attorney employed by or under contract with child support services represents only the state of Iowa. The sole attorney-client relationship for the child support services attorney is between the attorney and the state of Iowa. A private attorney acting under Iowa Code section 252B.6A is not a child support services attorney and is not a party to the action.

95.8(2) *Provision of services.* The special role of the child support services attorney is limited by the attorney-client relationship between the attorney and the state of Iowa. The provision of legal services by the child support services attorney is limited as follows:

a. The child support services attorney will not represent any person or entity other than the state of Iowa in the course of the attorney's employment by or contractual relationship with child support services.

b. Child support services will issue written disclosure of the attorney-client relationship between the attorney and the state of Iowa to recipients of child support services and to all parties in a review and adjustment proceeding.

95.8(3) *Communication concerning case circumstances.*

a. Child support services will provide case status information upon written request by any recipient of child support enforcement services or any party under the review and adjustment procedure unless otherwise prohibited by state or federal statute or rules pertaining to confidentiality.

b. All communications with other parties will be directed to those parties personally unless a licensed attorney has entered an appearance or notified child support services in writing that the attorney is representing a party. If any party is represented by counsel, all communications will be directed to counsel for that party.

c. When a party is receiving public assistance, child support services will refer any suspected fraud or questionable FIP expenditures to the appropriate governmental agencies.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.9(252B) Effective date of support. For all original orders established by child support services, the effective date of the support obligation under the orders will be the twentieth day following the date the order is prepared by child support services unless otherwise specified.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.10(252B) Continued services available to canceled FIP or Medicaid recipients. Support services will automatically be provided to persons who were eligible to receive support services as recipients of FIP or Medicaid and who were canceled from FIP or Medicaid. Continued support services will not be provided to a person who has been canceled from FIP or Medicaid when a claim of good cause, as defined at 441—Chapter 41 or 75, as appropriate, was valid at the time assistance was canceled or when one of the reasons for termination of services included in rule 441—95.7(252B) applies to the case.

Support services will be provided to eligible persons without application or application fee, subject to applicable enforcement fees.

95.10(1) *Notice of services.* When a family is no longer eligible for public assistance, the department will forward a form prescribed by the department to the family's last-known address within five working days of the notification of ineligibility to inform the family of the following:

a. Unless the family notifies the department to the contrary, services will continue.

b. The effect of continuing to receive support services, including the available services and the state's policies on fees, cost recovery, and distribution.

95.10(2) *Termination of services.*

a. A person may request that the department terminate support services at any time by completing and returning a form prescribed by the department, or in any other form of written communication, to child support services.

b. Continued support services may be terminated at any time for any of the reasons included in rule 441—95.7(252B).

95.10(3) *Reapplication for services.* A person whose services were denied or terminated may reapply for services by completing the application process described in subrule 95.2(2).

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.11(252B) Cooperation of public assistance recipients in establishing and obtaining support. If a person who is a recipient of FIP or Medicaid is required to cooperate with child support services in establishing paternity; in establishing, modifying, or enforcing child or medical support; or in enforcing spousal support, the following apply:

95.11(1) *Cooperation defined.* The person will cooperate in good faith in obtaining support for persons whose needs are included in the assistance grant or Medicaid household, except when good cause or other exception as defined in 441—Chapter 41 or 75 for refusal to cooperate is established.

a. The person will cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom assistance or Medicaid is claimed.

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

(3) Obtaining support payments for the person and the child for whom assistance is claimed and obtaining medical support for the person and child for whom Medicaid is claimed.

b. Cooperation includes the following actions by the person if the action is requested by child support services:

(1) Providing the name of the noncustodial parent and additional necessary information.

(2) Appearing at child support services to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the person that is relevant to achieving the objectives of the child support program.

(3) Appearing at judicial or other hearings, proceedings, or interviews.

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

(5) If the paternity of the child has not been legally established, submitting to blood or genetic tests pursuant to a judicial or administrative order. The person may be requested to sign a voluntary affidavit of paternity after being given notice of the rights and consequences of signing such an affidavit as required by Iowa Code section 252A.3A. However, the person will not be required to sign an affidavit or otherwise relinquish the right to blood or genetic tests.

c. The person will cooperate with child support services to the extent of supplying all known information and documents pertaining to the location of the noncustodial parent and taking action as may be necessary to secure or enforce a support obligation, establish paternity, or secure medical support. A person's cooperation with child support services includes completing and signing a form prescribed by the department, if requested, as well as documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

95.11(2) *Failure to cooperate.* Child support services will make the determination of whether a person has cooperated. Child support services will promptly send notice of a determination of noncooperation to the person on a form prescribed by the department and notify the FIP and Medicaid programs, as appropriate, of the noncooperation determination and the reason for the determination. The FIP and Medicaid programs will take appropriate sanctioning actions as provided in statute and rules.

95.11(3) *Good cause or other exception.*

a. A person who is a recipient of FIP assistance may claim a good cause or other exception for not cooperating, taking into consideration the best interests of the child as provided in 441—Chapter 41.

b. A person who is a recipient of Medicaid may claim a good cause or other exception for not cooperating, taking into consideration the best interests of the child as provided in 441—Chapter 75.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.12(252B) Cooperation of public assistance applicants in establishing and obtaining support. If a person who is an applicant of FIP or Medicaid is required to cooperate in establishing paternity; in establishing, modifying, or enforcing child or medical support; or in enforcing spousal support, the requirements in 441—Chapters 41 and 75 apply. The appropriate staff in the FIP and Medicaid programs are designees of child support services to determine noncooperation and issue notices of that determination until the referral to child support services is completed.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.13(252B) Cooperation in establishing and obtaining support in nonpublic assistance cases.

95.13(1) *Requirements.* The person receiving nonpublic assistance support services will cooperate with child support services by meeting all the requirements of rule 441—95.11(252B), except that the person may not claim good cause or other exception for not cooperating.

95.13(2) *Failure to cooperate.* Child support services will make the determination of whether or not the nonpublic assistance applicant or recipient of services has cooperated. Noncooperation will result in termination of support services. An applicant or recipient may also request termination of services under subparagraph 95.7(1)*"a"*(10).

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.14(252B) Charging pass-through fees. Pass-through fees are fees or costs incurred by the department for service of process, genetic testing, and court costs if the entity providing the service charges a fee for services. Child support services may charge pass-through fees to persons who receive continued services according to 441—95.10(252B) and to other persons receiving nonassistance services, except no fees may be charged to an obligee residing in a foreign country or to a foreign country if child support services is providing services under paragraph 95.2(2)*"b."*
[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.15(252B) Reimbursing assistance with collections of assigned support. For an obligee and child who currently receive assistance under FIP, the full amount of any assigned support collection that the department receives will be distributed according to rule 441—95.10(252B) and retained by the department to reimburse the FIP assistance.
[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.16(252B) Child support account. Child support services will maintain a child support account for each client. The account, representing money due the department, will cover all periods of time public assistance has been paid, commencing with the date of the assignment. Child support services will not maintain an interest-bearing account.
[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.17(252B) Emancipation verification. Child support services may verify whether a child will emancipate according to the provisions established in the court order prior to the child's eighteenth birthday.

95.17(1) *Verification process.* Child support services will send a form prescribed by the department to the obligor and obligee on a case if child support services has an address.

95.17(2) *Return information.* The obligor and obligee will be asked to complete and return the form to child support services. Child support services will use the information provided by the obligor or obligee to determine if the status of the child indicates that any previously ordered adjustments related to the obligation and a child's emancipation are necessary on the case.

95.17(3) *Failure to return information.* If the obligor and obligee fail to return the questionnaire, child support services will apply the earliest emancipation date established in the support order to the case and implement changes in support amounts required in the support order.

95.17(4) *Conflicting information returned.* If conflicting information is returned or made known to child support services, child support services will have the right to verify the child's status through sources other than the obligor and obligee.
[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

441—95.18(17A) Right of appeal.

95.18(1) Under this chapter, an administrative appeal pursuant to 441—Chapter 2506 will be limited to the following issues:

a. A person is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.6(17A), or a dispute based on the date of collection has not been acted on in a timely manner.

b. A termination in services has occurred as provided in rule 441—95.7(252B).

95.18(2) A hearing will not be granted under 441—Chapter 2506 when an appellant has a complaint about child support services collections actions other than those described in this rule. This includes the collection of an annual fee for child support services as specified in Iowa Code chapter 252B.
[**ARC 8961C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—95.19(17A) Appeal record. The record in an administrative appeal under this rule will include, in addition to those materials specified in Iowa Code section 17A.12(6), the notice of appeal and the verbatim record of the hearing.

[**ARC 8961C**, IAB 2/19/25, effective 4/1/25]

These rules are intended to implement Iowa Code chapters 252B, 252C, 252D and 17A.

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

◊ Two or more ARCs

1 Effective date of 95.1, definition of "Date of collection," and 95.3 delayed 70 days by the Administrative Rules Review Committee at its meeting held September 15, 1999; delayed until the end of the 2000 Session of the General Assembly at its meeting held October 11, 1999.

CHAPTER 96
INFORMATION AND RECORDS

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—96.1(252B) Access to information and records from other sources. In addition to statutes and other rules, the following entities shall provide information and records based on the following methods of requesting the information and within the following time frame:

96.1(1) *Oral or written request.* All persons and entities, including all for-profit, nonprofit, and governmental employers, must, within 15 days of receipt of a request, provide child support services or a child support agency of another state information on the employment, compensation, and benefits of any individual employed by the person or entity as an employee or contractor if child support services or the agency is providing services in relation to that individual. The request may be made orally, by letter, by form or by other written request listed in subrule 96.1(3); however, the fine and procedures described in rules 441—96.2(252B) through 441—96.6(252B) only apply if the request was by a written request listed in subrule 96.1(3).

96.1(2) *Subpoena.* All persons and entities shall comply with a child support services subpoena, issued by child support services, or an Administrative Subpoena, OMB Control No. 0970-0152, or its successor, issued by child support services or a child support agency of another state, as provided in Iowa Code section 252B.9. Child support services or a child support agency of another state may issue a subpoena regarding more than one individual. The person or entity must provide the information and records as directed in a form prescribed by the department or the Administrative Subpoena.

96.1(3) *Time to reply to a written request.* A person or entity who is sent any of the following must provide the information and records requested in the manner requested to child support services or child support agency of another state, as appropriate, within 15 days of the date of the request:

a. Any form prescribed by the department that requests information described in subrule 96.1(1).

b. A child support services subpoena, or an Administrative Subpoena, OMB Control No. 0970-0152, or its successor, as provided in subrule 96.1(2), from child support services or from a child support agency of another state.

c. A written request or form as provided in subrule 96.1(1) from a child support agency of another state.

[**ARC 8962C**, IAB 2/19/25, effective 4/1/25]

441—96.2(252B) Refusal to comply with written request or subpoena.

96.2(1) A parent or putative father in a support or paternity proceeding in which child support services or a child support agency of another state is providing services who fails to comply with a request or subpoena as provided in subrule 96.1(3) shall be subject to license sanctioning as provided in 441—Chapter 98.

96.2(2) An entity or a person who is not a parent or putative father as described in subrule 96.2(1) may refuse to comply under the circumstances provided in rule 441—96.3(252B).

[**ARC 8962C**, IAB 2/19/25, effective 4/1/25]

441—96.3(252B) Procedure for refusal.

96.3(1) *No information.* A person or entity who does not have any information or records requested or subpoenaed must respond as follows:

a. If the request or subpoena is a form from child support services under paragraph 96.1(3)*"a"* or *"b,"* the person or entity must sign and return to child support services the appropriate portion of the form indicating the lack of information or records.

b. If the request or subpoena is one listed in paragraph 96.1(3)*"c,"* the person or entity must send the child support agency of the other state a signed and dated written statement indicating the lack of information or records.

96.3(2) *Good cause.* The person or entity may claim good cause for refusing to comply as required in Iowa Code section 252B.9.

a. To claim good cause, the person or entity must file a request for a conference by mailing or submitting a written request to child support services that issued the request or subpoena within 15 days of the issuance of the request or subpoena.

b. If a child support agency of another state issued the request or subpoena, the person or entity may request a conference with child support services or with the child support agency of the other state. The person or entity shall request a conference with child support services by mailing or submitting a written request and a copy of the subpoena or document received from the child support agency of the other state to child support services. The person or entity must request a conference with the child support agency of the other state by following the requirements of that state's laws and regulations.

[**ARC 8962C**, IAB 2/19/25, effective 4/1/25]

441—96.4(252B) Conference conducted.

96.4(1) *Request or subpoena issued by child support services.* If child support services issued the request or subpoena, child support services will notify the person or entity and conduct a conference within ten days of receipt of the request for a conference. At the request of either child support services or the person or entity, the conference may be rescheduled one time. The conference may be conducted in person or by telephone.

96.4(2) *Request or subpoena issued by other state.* If a conference with child support services is requested based upon a request or subpoena issued by a child support agency of another state, the department will request that agency send an interstate referral and appropriate information to child support services or central registry.

a. Child support services will notify the person or entity and conduct a conference within ten days of opening a case based upon an interstate referral and appropriate information. If child support services does not receive an interstate referral and appropriate information within 60 days of the department's request, the request or subpoena received under subrule 96.1(3) shall be void, and child support services will notify the person or entity that the request or subpoena is void.

b. The voiding of a request or subpoena under this subrule does not prevent the issuance of subsequent requests or subpoenas.

96.4(3) *Submission of information.* On or before the conference date, the person or entity must submit information to child support services that demonstrates a mistake in the identity of the person or entity, or a mistake in the identity of the individual who is the subject of the request or subpoena, or that demonstrates a specific prohibition under federal law to release the information or records. Child support services may extend the time to conduct the conference an additional ten days to allow time for the person or entity to provide the information.

96.4(4) *Notice of findings.* Following the conference, child support services will issue a notice pursuant to Iowa Code section 252B.9.

[**ARC 8962C**, IAB 2/19/25, effective 4/1/25]

441—96.5(252B) Fine assessed.

96.5(1) *Conditions resulting in fine.* Child support services will assess a fine of $100 per refusal and notify the person or entity of the fine if any one of the following applies:

a. Ten days have passed since child support services issued a notice under subrule 96.4(4) stating child support services determined there is no good cause to refuse to comply with the request or subpoena, and the information or records have not been received.

b. Fifteen days have passed since child support services issued the request or subpoena and the information or records have not been received, nor has the person or entity filed a request for a conference.

c. Fifteen days have passed since a child support agency of another state has issued the request or subpoena, and that agency sends an interstate referral to child support services requesting enforcement of the request or subpoena because the information or records were not received.

96.5(2) *Definition of refusal.* One refusal is a refusal to supply information or records based on one written request, or one subpoena regarding one or more individuals.

96.5(3) *Notification of fine.* If child support services assesses a fine, child support services will notify the person or entity by regular mail with proof of service completed according to Rule of Civil Procedure 1.442. The person or entity shall have 30 days from the date of the notice to pay the fine.
[**ARC 8962C**, IAB 2/19/25, effective 4/1/25]

441—96.6(252B) Objection to fine or failure to pay.

96.6(1) *Objection filed.* The person or entity may object to the imposition of the fine by filing an application for judicial review in district court within 30 days of issuance of the notice of the fine and sending a copy of the application to child support services.

96.6(2) *Petition to compel.* If the person or entity fails to pay the fine imposed and does not file an application for judicial review within the time provided in this rule, child support services may file a petition to compel the person or entity to comply with the request, subpoena or fine in district court in the county in which the underlying support order or pending matter is filed. If there is no support order or pending matter filed in district court in Iowa, then child support services may file the petition in the county in which the person resides or the person or entity has its principal place of business.

96.6(3) *Certification to court.* If the person, entity, or child support services files an action in district court, child support services will certify a copy of the following, as appropriate, to the court prior to a hearing:

a. Proof of service of the request or subpoena.

b. Proof of service of the notice of assessment of a fine.

c. Written decision following a conference.

96.6(4) *Failure to comply with court order.* Failure of the person or entity to comply with an order of the district court will be subject to enforcement through contempt of court.
[**ARC 8962C**, IAB 2/19/25, effective 4/1/25]

441—96.7(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.
[**ARC 8962C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 17A and section 252B.9.

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CHAPTER 97
COLLECTION SERVICES CENTER

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—97.1(252B) Definitions. The definitions of terms used in this chapter will follow those terms defined in rule 441—95.1(252B) with the exception or addition of the following:

"Collection services center" means the public agency designated to receive, record, monitor, and disburse support payments as defined in Iowa Code section 598.1, 252B.15 or 252D.16, in accordance with Iowa Code sections 252B.13A and 252B.14.

"Correlated non-IV-D case" means a non-IV-D case where income withholding information must be maintained by child support services in order to properly process an income withholding payment because the obligor has both a non-IV-D and a current or former IV-D case.

"Electronic funds transmission" means, for purposes of this chapter, the use of a NACHA-approved child support format for the electronic transmission of funds to the collection services center.

"Employee" means the same as defined in Iowa Code section 252G.1.

"Former IV-D case" means a case that previously received services from child support services under rule 441—95.2(252B) but currently receives only payment processing services from the collection services center.

"Insufficient funds payment" means a support payment by check or other financial instrument that is dishonored, not paid, or the funding of the payment is determined to be inadequate.

"IV-D case" means a case that receives services from child support services under rule 441—95.2(252B), including payment processing services from the collection services center.

"NACHA-approved child support format" means a child support payment transmission format approved by the National Automated Clearing House Association (NACHA).

"Non-IV-D case" means a support order that never received services from child support services under rule 441—95.2(252B) but that receives payment processing services from the collection services center for income withholding payments.

"Obligee" means the guardian, custodial parent, person, or entity entitled to receive support payments.

"Obligor" means a parent, relative, or any other person declared to be legally liable for the support of a child or the custodial parent or guardian of the child.

"Payor of income" means the same as defined in Iowa Code section 252D.16.

"Support payment" means the same as "support" or "support payments" as defined in Iowa Code section 252D.16.

"Website" means the website operated by the department for the purpose of allowing a payor of income to make a support payment through electronic transmission to the collection services center.

[**ARC 8963C**, IAB 2/19/25, effective 4/1/25]

441—97.2(252B) Transfer of records and payments. For non-IV-D cases, the clerk of court shall provide core case information to child support services upon the filing of a new income withholding order or upon the request of child support services. "Core case information" means information listed in paragraphs 97.2(1)*"a"* and *"b"* and subrule 97.2(2). For IV-D and correlated non-IV-D cases, the clerk of court shall provide detailed case information to child support services upon request. After the establishment of a case, child support services will send notices of transfer to obligors and obligees based upon case type.

97.2(1) *Transfer of information on non-IV-D and correlated non-IV-D cases.*

a. In non-IV-D cases, child support services will request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:

(1) The obligor's name and address.

(2) The obligee's name and address.

(3) The court order numbers.

b. In correlated non-IV-D cases, child support services will request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:

(1) The obligor's name and address.

(2) The obligee's name and address.

(3) The court order numbers.

(4) The income withholding order.

c. The clerk of the district court must provide case information to child support services on a regular basis when an income withholding order is filed with a clerk of court or when child support services requests the information in order to process a payment.

d. Child support services will automatically create cases for payment processing based upon the information received from the clerks of court.

97.2(2) *Transfer of information on IV-D cases.* In IV-D cases, the clerk of the district court shall provide child support services with the following information if the information has been provided to the clerk upon request of child support services:

a. The obligee's name, date of birth, last-known mailing address, the social security number if known and, if different in whole or part, the names of the persons to whom the obligation of support is owed by the obligor.

b. The name, birth date, social security number, and last-known mailing address of the obligor.

c. A copy of all support orders that establish or modify a support amount.

d. The names, social security numbers, and dates of birth of any minor dependents for whom support is ordered, if available.

e. A record of any support payments received by the clerk of district court prior to the transfer of case information and any payments received by the collection services center and the date of transfer to the collection services center.

f. A record of any determination of controlling order under the Uniform Interstate Family Support Act.

[**ARC 8963C**, IAB 2/19/25, effective 4/1/25]

441—97.3(252B) Support payment records. Each IV-D, former IV-D and non-IV-D case type shall have an official payment record.

97.3(1) *Official records for cases.* The official payment records for each case type are maintained by a designated entity.

a. The collection services center will establish, maintain and certify the official support payment records for IV-D or former IV-D cases.

b. The clerk of the district court shall establish, maintain and certify the official support payment records for non-IV-D and correlated non-IV-D cases. The collection services center will establish and maintain records for receipt and disbursement of income withholding payments for these cases but will not certify these records as the complete payment record.

97.3(2) *Informal conference for payment records.* Child support services will provide an informal conference or desk review regarding the contents of any support payment record to the obligor or obligee upon request.

a. In IV-D or former IV-D cases, the conference shall be available to review the payment record and to answer questions of the obligee or obligor regarding the accuracy of the record.

b. In non-IV-D and correlated non-IV-D cases, the conference shall be available to review the accuracy of the contents of any record of income withholding payments.

97.3(3) *Certified payment records.* Child support services will provide certified copies of the official support payment records as described in paragraph 97.3(1)*"a"* in accordance with Iowa Code section 252B.9.

[**ARC 8963C**, IAB 2/19/25, effective 4/1/25]

441—97.4(252B) Method of payment. Payments will be accepted in specific forms from obligors and payors of income.

97.4(1) *Form of payment.* Except as otherwise provided in this rule and in rule 441—97.5(252D), support payments may be paid in the form of cash, check, bank draft, money order, preauthorized withdrawal of funds, or other financial instrument, and sent by mail to the collection services center or by electronic transmission of funds.

97.4(2) *Treatment of insufficient funds payments.* Child support services will have a process in place to handle insufficient funds payments.

a. An obligor submitting an insufficient funds support payment to the collection services center will be required to submit payments by cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

b. A payor of income submitting an insufficient funds support payment to the collection services center is required to submit payments through electronic funds transmission, cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

c. Insufficient funds payments will not be credited to the collection services center account for the obligor or will be removed from the account if credited before sufficiency was verified. Insufficient funds support payments will be subject to additional collection by the collection services center for the dishonored amount.

d. The collection services center may not process additional payments other than cash, bank drafts or money orders from an obligor or payor of income who has previously submitted insufficient funds payments without first verifying the payment. The collection services center will have a process in place to allow the obligor or the payor of income the opportunity to replace any additional moneys submitted for payment of support before processing in order to avoid additional insufficient funds entries into the official payment records on the affected cases.

97.4(3) *Distribution of payment.* Nonincome withholding support payments received by the collection services center in IV-D, former IV-D, non-IV-D, or correlated non-IV-D cases that are not directed to a specific account or support obligation will first be applied proportionately to the current support obligation on all cases for the obligor and, secondly, to the support arrearages owed by the obligor.

[**ARC 8963C**, IAB 2/19/25, effective 4/1/25]

441—97.5(252D) Electronic transmission of payments. Payors of income must electronically transmit to the collection services center the amounts withheld under an income withholding order.

97.5(1) *Thresholds for electronic funds transmission.* A payor of income must transmit payment through electronic funds transmission if either of the following applies:

a. The payor of income employs 100 or more employees and uses an agent for payroll processing.

b. The payor of income employs 200 or more employees.

97.5(2) *Use of the website.* Unless paragraph 97.4(2)*"b"* applies, a payor of income required to use electronic funds transmission under subrule 97.5(1) may elect to submit payments electronically by using the website if the payor of income determines that using electronic funds transmission would cause undue hardship.

97.5(3) *Implementing electronic funds transmission.* A payor of income implementing electronic funds transmission shall complete all the following in advance of transmitting payments electronically:

a. Contact child support services to obtain file layout and case reconciliation information.

b. Provide to the collection services center:

(1) The contact information for the person responsible for electronic funds transmission for the payor of income or the payor of income's agent for payroll processing;

(2) The contact information for the person responsible for payroll accounts for the payor of income or the payor of income's agent for payroll processing;

(3) The name and address of the authorized financial institution from which the payment will be withheld; and

(4) A sample file layout in a NACHA-approved child support format and, if necessary, a test file in a NACHA-approved child support format.

c. If needed upon review by the collection services center:

(1) Make corrections to the file layout to meet a NACHA-approved child support format, and

(2) Provide a corrected copy to the collection services center for review.

d. Upon approval of the file layout by the collection services center, provide an implementation date before the first submission of payment through electronic funds transmission.

97.5(4) *Maintaining information and file format after implementation.* A payor of income that has implemented electronic funds transmission shall:

a. Transmit both payment amounts and detailed information records in accordance with a NACHA-approved child support format.

b. Advise the collection services center of a payment error within two business days.

c. Provide the collection services center ten working days' advance notice when changing between NACHA-approved child support formats.

d. Correct case number or file problems identified by the collection services center before sending any additional files.

97.5(5) *Exemption from electronic transmission.* To avoid undue hardship, a payor of income that has fewer than 200 employees or a payor of income that has fewer than 100 employees and uses an agent for payroll processing is exempt from using electronic transmission unless subrule 97.4(2) applies.

[**ARC 8963C**, IAB 2/19/25, effective 4/1/25]

441—97.6(252B) Authorization of payment. The collection services center must authorize the generation of payments for support paid. The collection services center will issue payments as follows:

97.6(1) *Submittal of information to department of administrative services.* In order to disburse payments to the obligee within two working days, the collection services center will submit information daily to the department of administrative services to issue a warrant or electronic file transfer (EFT) payment to the obligee.

97.6(2) *Release of funds.* The following workday, an electronic transfer of funds will be sent to the designated account of the obligee or an alternate account to be accessed by the obligee through an electronic access card, or if subrule 97.6(5) applies, a state warrant may be sent by regular mail to the last-known address of the obligee.

97.6(3) *Electronic transfer.* Obligees who want electronic transfer of support payments to a designated account shall complete a form prescribed by the department and submit it to the collection services center. Unless subrule 97.6(5) applies, any obligee not using automatic deposit to a designated account will be issued an electronic access card for receipt of support payments.

97.6(4) *Walk-ins.* Support payments will not be hand-delivered to the obligee on a walk-in basis.

97.6(5) *Warrants.* The collection services center may authorize generation of a warrant if any one of the following conditions applies:

a. Generation of a warrant is necessary to meet federal requirements to disburse a payment to an obligee within two working days when electronic transfer is not feasible.

b. The obligee has not requested automatic deposit to a designated account of the obligee, and payment is from a source that is nonrecurring or is not expected to continue in a 12-month period.

c. The obligee has not requested automatic deposit to a designated account of the obligee and has asserted in writing on a form prescribed by the department that one of the exemptions listed in this paragraph applies. To claim an exemption, the obligee must return the form prescribed by the department to the collection services center within ten days of the date the form was issued. An exemption granted under this paragraph is subject to periodic review by the collection services center. The exemptions available under this paragraph are:

(1) A physical disability imposes a hardship in accessing an electronically transferred payment.

(2) A mental disability imposes a hardship in accessing an electronically transferred payment.

(3) A language barrier imposes a hardship in accessing an electronically transferred payment.

(4) A literacy barrier imposes a hardship in accessing an electronically transferred payment.

(5) The obligee's home and work addresses are more than 30 miles from an automated teller machine and more than 30 miles from a financial institution where the account funds can be accessed.

d. The representative payee, court appointee, or trustee notifies the collection services center or unit in writing that one of the following applies:

(1) The obligee is under a court-ordered guardianship or conservatorship.

(2) The obligee is involved in other legal proceedings, including bankruptcy, which require payments to be sent to a trustee or other representative payee.

[**ARC 8963C**, IAB 2/19/25, effective 4/1/25]

441—97.7(252B) Processing misdirected payments. If the collection services center receives a payment for which a corresponding obligee cannot be identified, the collection services center will contact the person or entity that directed the payment to obtain additional information. Payments inappropriately directed to the collection services center will be returned to the person or entity sending the payment.
[**ARC 8963C**, IAB 2/19/25, effective 4/1/25]

441—97.8(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.
[**ARC 8963C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 17A and sections 252B.13A through 252B.17 and 252D.17.

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CHAPTER 98
SUPPORT ENFORCEMENT SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—98.1(252E) Definitions.

"Current support" means an amount for the ongoing support of a child and means the same as "support" as defined in Iowa Code section 252D.16.

"Delinquent support" means a payment, or portion of a payment, including interest, not received by the clerk of the district court or other designated agency at the time it was due. In addition, delinquent support will also include payments for parental liabilities not received as specified pursuant to 441—Chapter 156.

"Federal nontax payment" means an amount payable by the federal government that is subject to administrative offset for support under the federal Debt Collection Improvement Act, PL 104-134 (April 26, 1996).

"Medical support" means the same as defined in Iowa Code section 252E.1.

"Mistake of fact" means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral.

"Obligee" means the same as defined in Iowa Code section 252E.1.

"Obligor" means the same as defined in Iowa Code section 252E.1.

"Offsets" means a federal income tax refund or federal nontax payment as described in rule 441—98.30(252B).

"Setoffs" means a state income tax refund, rebate or payment owed to a person by a state agency as described in the process found at 701—Chapter 26 and in rules 441—98.28(252B) and 441—98.29(252B).

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—98.2(252E) Medical support health benefit plan information.

98.2(1) *Information from an employer.* Child support services will gather information concerning a health benefit plan an employer may offer an obligor as follows:

a. Child support services may send a form prescribed by the department whenever a potential employer is identified.

b. Child support services will secure information about health care coverage from a known employer on a form prescribed by the department when a form prescribed by the department or an order has been forwarded to the employer pursuant to Iowa Code section 252E.4.

98.2(2) *Information from an obligor.* Child support services may secure medical support information from an obligor on a form prescribed by the department.

98.2(3) *Disposition of information.* Child support services will provide the information:

a. To the Medicaid agency and to the obligee, when requested, when the dependent is a recipient of Medicaid.

b. To the obligee, when requested, when the dependent is not a recipient of Medicaid.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.3(252E) Medical support insurer authorization. When the obligor does not provide to the insurer the signed documents necessary to enroll and process claims for the dependent for whom support is ordered, the insurer is authorized to accept the signature of the obligee or the department's designee on necessary forms. For purposes of this chapter, the third-party liability unit is the department's designee when support is assigned.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.4(252E) Medical support enforcement.

98.4(1) *Medical support enforcement.* Medical support may be enforced pursuant to Iowa Code section 252E.12.

98.4(2) *Health care coverage.*

a. If an obligor was ordered to provide health care coverage under an order but did not comply with the order, child support services may implement the order by forwarding to the employer a copy of the order, an ex parte order as provided in Iowa Code section 252E.4, or on a form prescribed by the department.

b. If child support services implements an order under this subrule, child support services will send a notice to the obligor at the last-known address of the obligor by regular mail. The notice will contain the following information:

(1) A statement of the obligor's right to an informal conference.

(2) The process to request an informal conference.

(3) The obligor's right to file a motion to quash with the district court.

98.4(3) *Termination of employment.* When child support services receives information indicating the obligor's employment has terminated, child support services will secure the status of the health benefit plan by sending a form prescribed by the department to the employer.

If no response is received within 30 days of sending a form prescribed by the department, child support services will send a second request on a form prescribed by the department to the employer.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.5(252E) Contesting enforcement of medical support. The obligor may contest the enforcement of medical support by means of an informal conference with child support services, or by filing a motion to quash.

98.5(1) *Motion to quash.* Procedures for filing a motion to quash the order are specified under Iowa Code sections 252D.31 and 252E.6A.

98.5(2) *Informal conference.*

a. The obligor will be entitled to only one informal conference for each new employer to which child support services has forwarded a form prescribed by the department or an order under Iowa Code section 252E.4 to enforce medical support.

b. Procedures for the informal conference are as follows:

(1) Child support services will inform the obligor in writing of the right to request an informal conference.

(2) The obligor may request an informal conference with child support services if the obligor believes the enforcement was entered in error.

(3) The obligor shall request an informal conference in writing, within 15 calendar days from the date of the notice of the right to an informal conference, or at any time if a mistake of fact regarding the identity of the obligor is believed to have been made.

(4) Child support services will schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor's representative.

(5) Child support services may conduct the conference in person or by telephone.

(6) If the obligor fails to attend the conference, only one alternative time will be scheduled by child support services.

(7) Child support services will issue a written decision to the obligor within ten calendar days of the conference.

c. The issues to be reviewed at the conference shall be as follows:

(1) Whether the identity of the obligor is in error.

(2) Whether the obligor is already providing health care coverage for the dependent.

(3) Whether the availability of dependent health care coverage is in error.

(4) Whether the obligor was ordered to provide health care coverage under the support order.

d. The results in an informal conference will in no way affect the right of the obligor to file a motion to quash the order under Iowa Code section 252E.6A.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.6(252D) Income withholding of delinquent support. When there is a delinquency in an amount equal to the support payable for one month as specified by an order for support or reimbursement order and child support services is providing services under 441—Chapter 95, child support services will enter an

order to withhold the obligor's income not exempt by state or federal law to require the income withheld to be paid to the collection services center to pay the support obligation. An income withholding order will also be entered to collect the unpaid balance of a judgment for the reimbursement of a support debt when a repayment schedule is not specified in the order establishing the judgment.
[**ARC 8964C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—98.7(252D) Income withholding amounts. Child support services will determine the amount to be withheld by the employer or other income providers as follows:

98.7(1) *Current support obligation exists.* When a current support obligation exists, the amount withheld will be an amount equal to the current support obligation, and an additional amount equal to 20 percent of the current support obligation to be applied toward the liquidation of any delinquency.

98.7(2) *Current obligation ended.* When the current support obligation has ended or has been suspended, the income withholding order will remain in effect until any delinquency has been satisfied. The amount withheld will be equal to the amount of the most recent prior current support obligation that is greater than zero. However, in the following circumstances, the amount withheld will be 20 percent of the amount owed for current support at the time the obligation ended or was suspended:

a. There has been a change of court-ordered physical care from the obligee to the obligor.

b. The obligee and obligor have reconciled and have obtained a modification ending the current support obligation.

c. The current obligation is suspended through the suspension process.

d. In a foster care case, the order for parental liability ended when the child left placement, or an order ending the liability has been entered and the child in foster care has returned to the home of a parent ordered to pay parental liability. In this situation, the amount withheld will be reduced to 20 percent of the current support amount when the obligation ended, but only for the parent with whom the child resides.

98.7(3) *No support ordered.* When there is no current child support ordered and the obligation is solely the result of a judgment that does not specify a repayment schedule, the withholding amount will be set at the amount for one person from the family investment program (FIP) schedule of basic needs.

98.7(4) *Lump-sum income source.* Notwithstanding subrules 98.7(1), 98.7(2), and 98.7(3), when the obligor is paid by a lump-sum income source, the withholding amount may include all current and delinquent support due through the current month. Lump-sum income includes income received in a sole payment or in payments that occur at two-month or greater intervals.
[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.8(252D) Amendment of amount of withholding due to hardship.

98.8(1) *Request for amendment.* If subrule 98.7(2) or 98.7(3) applies, the obligor may request at any time an amendment of the amount withheld as payment toward the delinquency or reimbursement on the grounds of hardship. The obligor must submit the request in writing to child support services.

98.8(2) *Hardship criterion.* Hardship exists if the obligor's income is equal to or less than 200 percent of the poverty level for one person according to the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. Section 9902(2) (as amended to August 1, 2024).

a. If hardship is claimed by the obligor, child support services may verify income from:

(1) The employer or other income provider of the obligor.

(2) The obligor.

(3) The state employment security agency.

(4) Other records available in accordance with Iowa Code section 252B.9.

b. If the hardship criterion is met, the amount withheld as payment toward the delinquency may be amended as follows:

(1) The obligor's gross yearly income will be divided by 200 percent of the established yearly gross poverty level income for one person. That amount will be multiplied by .5. The resulting figure will be multiplied by the most recent prior current support obligation or the amount determined pursuant to subrule 98.7(3), as applicable, to determine the amended amount. Notwithstanding this calculation, the amended amount will not be less than $15 per month.

(2) If criteria for withholding 20 percent toward liquidation of any delinquency are also met, the lesser of 20 percent or the amended amount determined in subparagraph 98.8(2)*"b"*(1) is to be withheld.

98.8(3) *Hardship period.* If the hardship criterion in subrule 98.8(2) is met, child support services will grant the amended amount of withholding for a period of two years, subject to the provisions of subrule 98.8(6). However, if the obligor is receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits, the obligor is deemed to continue to meet the hardship criterion for the duration of those benefits.

98.8(4) *Denying requests.* A hardship request may be denied if:

a. The criterion in subrule 98.8(2) is not met.

b. The obligor has been granted an amended amount of withholding based on this rule within the last two years and that hardship period will not expire in less than 30 days.

c. The obligor's previous hardship period expired within the last six months and, within 30 days prior to the expiration date of the previous hardship period, the obligor did not submit the following to child support services:

(1) A written request for hardship; or

(2) Verification of the obligor's income, and child support services was not able to verify the obligor's income as described in paragraph 98.8(2)*"a."*

98.8(5) *Notice requirements.* Child support services will provide written notification to the obligor of the result of the hardship request.

a. When a hardship request is granted, the written notification will include the amended amount of withholding and the date the hardship period will expire.

b. When a hardship request is denied, the written notification will include the reason for denial.

98.8(6) *Termination of hardship prior to expiration date.* The hardship period will automatically end, regardless of expiration date, if any of the following occurs:

a. A current support obligation is added to the support order.

b. The current support obligation was previously suspended and is reinstated.

c. The delinquency has been paid in full.

d. The obligor was receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits at the time the hardship request was granted, and child support services has verified that the obligor is no longer receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.9(252D) Immediate income withholding. Immediate withholding of income pursuant to Iowa Code section 252D.8 is automatic without additional notice to the obligor unless:

98.9(1) *Good cause exists.* Good cause is found to exist by the court or child support services. For purposes of this rule, "good cause" is defined as the posting of a secured bond by the obligor sufficient to pay all current and future child support obligations, including any delinquency that may accrue.

98.9(2) *Written agreement exists.* A written agreement is reached between both parties that provides for an alternative arrangement for payment of child support subject to the following conditions:

a. Unless approved by child support services, written agreements between the obligee and obligor to waive immediate income withholding become void when child support is assigned to this state or to another state pursuant to a statute of that jurisdiction.

b. All payments pursuant to any written agreement will be paid as directed in Iowa Code sections 252B.14 and 598.22.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.10(252D) Approval of request for immediate income withholding. When the obligee or other party to the proceeding requests immediate withholding, child support services will determine whether the request will be approved.

98.10(1) *Basis for approval.* Approval of a request for immediate income withholding by child support services may be based on:

a. Past payment record of the obligor that demonstrates an inconsistent compliance with the support order.

b. Whether the state of Iowa is providing public assistance.

98.10(2) *Request denied.* Child support services may not approve a request for immediate income withholding on cases where no public assistance has been expended and there is a prior written agreement between the obligee and obligor that has been approved by court order.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.11(252D) Immediate income withholding amounts. The amount withheld will be the amount of the current support obligation as specified in the support order. If a judgment for accrued support is established in the support order, the amount withheld will be the amount due for current support and the periodic payment amount due for the accrued support as specified in the order. If no periodic payment for the accrued support is established in the support order, the amount withheld will be the amount due for current support plus 10 percent of the amount of the current obligation to be applied to the accrued support.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.12(252D) Immediate income withholding amounts when current support has ended. When the child support obligation has ended, the amounts to be withheld will be in accordance with subrule 98.7(2).

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.13(252D,252E) Income withholding for medical support. An income withholding order or notice of income withholding may also include provisions for enforcement of medical support when medical support is included in the support order. The income withholding order or notice of income withholding may require implementation of dependent health care coverage pursuant to Iowa Code chapter 252E or the withholding of a dollar amount for medical support. Amounts withheld for medical support will be determined in the same manner as amounts withheld for child support.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.14(252D,252E) Maximum amounts to be withheld for income withholding. An income withholding order or a notice issued by child support services will require that the employer or other income provider withhold no more than the maximum amounts allowed under the Federal Consumer Credit Protection Act, 15 U.S.C. Section 1673(b) (as amended to August 1, 2024).

98.14(1) The amount of income subject to withholding will be limited to 50 percent of the nonexempt disposable income of the obligor unless there is more than one support order for which the obligor is obligated and the criteria of 15 U.S.C. Section 1673(b) (as amended to August 1, 2024) are met, or the obligor agrees to a greater amount within these limits.

98.14(2) Disposable income means that part of the earnings of any individual remaining after the deduction from those earnings of any amounts mandated by law to be withheld.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.15(252D) Income withholding for multiple obligations. In the event that an obligor has more than one support obligation that is being enforced by child support services, child support services may enter an income withholding order to enforce each obligation. The amount specified to be withheld on the delinquency under the income withholding order or notice will be determined in accordance with rule 441—98.7(252D).

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.16(252D) Income withholding notice to employer and obligor. Child support services will send the obligor and the employer or other income provider a notice of income withholding as follows:

98.16(1) *Notice to employer.* Child support services may send notice to the employer or other income provider by regular mail or by electronic means in accordance with Iowa Code chapter 252D. If child support services is sending notice by regular mail, it will send a form prescribed by the department or a notice in the standard format prescribed by 42 U.S.C. Section 666(b)(6)(A) (as amended to August 1,

2024). If child support services is sending the notice by electronic means, it may include notice of more than one obligor's order and need only state once provisions that are applicable to all obligors, such as the information in paragraphs 98.16(1)*"d,""f,""g,"* and *"i."* The statement of provisions applicable to all obligors may be sent by regular mail or electronic means. The notice of income withholding will contain information such as the following:

a. The obligor's name and social security number.

b. The amount of current support to withhold.

c. The amount of support to withhold for payment of delinquent support, if any.

d. The amount an income provider may deduct for costs of processing each support payment.

e. The child support case number.

f. The location to which payments are sent.

g. The maximum amount that can be withheld for payment of support as specified in rule 441—98.14(252D,252E).

h. The method to calculate net income.

i. Responsibilities of the income provider as specified in Iowa Code section 252D.17.

j. Responsibility, if any, of the income provider to enroll the obligor's dependent for coverage under a health benefit plan.

98.16(2) *Notice to obligor.* A form prescribed by the department will be sent to the last-known address of the obligor by regular mail. The notice will contain the following information:

a. A statement of the obligor's right to an informal conference.

b. The process to request an informal conference.

c. The obligor's right to claim hardship criteria and the process for a claim.

d. The obligor's right to file a motion to quash the income withholding order or notice with the district court.

e. The information provided to the employer or other income provider, or a copy of the notice sent to the employer or other income provider.

f. The amount of any delinquency.

98.16(3) *Standard format.* As provided in Iowa Code section 252D.17, an order or notice of an order for income withholding will be in a standard format and on a form prescribed by the department. Child support services will make a copy of the form available to the state court administrator and the Iowa state bar association.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.17(252D) Contesting the income withholding. The obligor may contest the income withholding by means of an informal conference with child support services or by filing a motion to quash.

98.17(1) *Motion to quash.* Procedures for filing a motion to quash the order or the notice of income withholding are specified in Iowa Code chapter 252D.

98.17(2) *Informal conference.*

a. The obligor will be entitled to only one informal conference for each new or modified income withholding order or notice issued by child support services that specifies a new or modified total amount to withhold.

b. Procedures for the informal conference are as follows:

(1) Child support services will inform the obligor in writing of the right to request an informal conference.

(2) The obligor may request an informal conference with child support services if the obligor believes the withholding is in error.

(3) The obligor will request an informal conference in writing.

(4) Child support services will schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor's representative.

(5) Child support services may conduct the conference in person or by telephone.

(6) If the obligor fails to attend the conference, only one alternative time will be scheduled by child support services.

(7) Child support services will issue a written decision to the obligor within ten calendar days of the conference.

(8) If child support services has not complied with rule 441—98.7(252D), it will then adjust the income withholding amount.

c. The issues to be reviewed at the conference will be as follows:

(1) For all income withholding orders or notices, whether:

1. The identity of the obligor is in error.

2. The amount of the current support obligation is in error.

(2) For orders or notices resulting from the existence of a delinquency, whether:

1. The amount of delinquent support is in error.

2. For income withholding orders or notices, whether the guidelines described at rule 441—98.7(252D) were followed.

(3) For immediate income withholding orders or notices, whether the criteria of rules 441—98.9(252D) and 441—98.10(252D) were appropriately applied.

d. The results of an informal conference will in no way affect the right of the obligor to file a motion to quash the income withholding order or notice with the court.

98.17(3) *Income withholding issued from another state.* Child support services will follow procedures for a motion to quash or a request for hardship or conduct an informal conference based on an income withholding order or notice issued in another state only if child support services is providing services under 441—Chapter 95.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.18(252D) Termination of income withholding. Child support services may, by ex parte order, terminate an income withholding order under the following conditions:

98.18(1) *Order entered in error.* Child support services will terminate an income withholding order upon determination that the order was entered in error as follows:

a. The person named as the obligor in the income withholding order is not the person required to provide support under the support order being enforced.

b. For orders resulting from the existence of a delinquency, the required minimum delinquency did not exist at the time the income withholding order was entered.

98.18(2) *No support due.* In cases for which services are being provided by child support services, child support services will terminate an income withholding order previously entered by child support services when the current support obligation has terminated and when the delinquent support obligation has been fully satisfied as applicable to all of the children covered by the income withholding order. In no case will payment of overdue support be the sole basis for termination of withholding.

98.18(3) *Other circumstances.* Child support services may revoke an income withholding order under other circumstances provided the conditions of Iowa Code chapter 252D are met.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.19(252D) Modification of income withholding. Child support services may modify a previously issued income withholding order or notice according to the guidelines established under rule 441—98.7(252D) if it is determined that:

98.19(1) *Current support obligation changed.* There has been a change in the amount of the current support obligation.

98.19(2) *Amount in error.* The amount required to be withheld under the income withholding order or notice is in error as follows:

a. The amount required to be withheld as current support is not the amount specified in the order for support being enforced.

b. The guidelines established in rule 441—98.7(252D) were not followed.

98.19(3) *Past-due support paid.* Any past-due support debt has been paid in full. The withholding order or notice will be modified to require that only the current support obligation be withheld from the income of the obligor. Should a delinquency later accrue, the withholding order or notice may again be

modified to secure an additional payment toward the delinquency. The amount of the arrears payment will be set at 20 percent of the current support amount.

98.19(4) *Income withholding and determination of controlling orders.* An obligation amount different from what child support services has been enforcing is established upon the determination of controlling order as allowed in Iowa Code section 252K.207. Upon the change to the new obligation amount, the amount withheld to be applied toward the liquidation of any delinquency will be 20 percent.

98.19(5) *Income withholding and review and adjustment of orders.* Child support services has conducted a review of the obligation pursuant to 441—Chapter 99. Child support services will modify the amount withheld to be applied toward the liquidation of any delinquency to 20 percent upon completion of the review and adjustment process.

98.19(6) *Implementation or termination of amended amount of withholding due to hardship.* Child support services has determined that the withholding order should be modified based upon the hardship provisions in rule 441—98.8(252D).

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.20(252D) Refunds of amounts improperly withheld. Child support services will refund to the obligor any amounts improperly withheld and received by the department under an income withholding order or notice issued by child support services, subject to the following:

98.20(1) *Services provided by the department.* Only those amounts received by the department during the period enforcement services are being provided are subject to refund.

98.20(2) *Satisfaction of amount to withhold.* No refund will be made unless amounts have been collected that fully satisfy the amount specified in the income withholding order or notice for the withholding period during which income has been generated.

98.20(3) *When issued.* Any amounts received in excess of the amounts specified in the order or notice to withhold will be issued to the obligor within 30 days of discovery by child support services unless the obligor requests in writing that these amounts be credited toward the delinquency or future child support. If there is a dispute regarding whether there is an overpayment, the obligor may request an informal conference by following the procedures set out in subparagraphs 98.17(2)*"b"*(3) through (7). This procedure will not preclude the obligor from utilizing other civil remedies.

98.20(4) *Recovery by child support services.* The department may recover payments from the obligee in excess of those described in subrule 98.20(2) that have been received by the department and improperly forwarded to the obligee.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.21(96) Child support intercept of unemployment insurance benefits. When the department of workforce development notifies child support services that an individual who owes a child support obligation being enforced by child support services has been determined to be eligible for unemployment insurance benefits, child support services will enforce a child support obligation that is owed by an obligor but is not being met by intercept of unemployment insurance benefits. "Owed but not being met" means either current child support not being met or arrearages that are owed.

98.21(1) *Withholding.* Child support services will intercept unemployment insurance benefits by initiating a withholding of income pursuant to Iowa Code chapter 252D and this chapter. The amount to be withheld through a withholding of unemployment insurance benefits will not exceed the amount specified in 15 U.S.C. Section 1673(b) (as amended to August 1, 2024).

98.21(2) Reserved.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.22(252B) Administrative seek employment order. Child support services may enter an ex parte order requiring the obligor to seek employment in accordance with Iowa Code section 252B.21.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.23(252B) Effective date of seek employment order. The seek employment order will be effective 15 days after issuance of the order to the obligor. This 15-day period will serve as advance notice to the obligor.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.24(252B) Method and requirements of reporting for administrative seek employment order. The obligor shall complete a form prescribed by the department, which will be submitted to child support services on a weekly basis throughout the duration of the order unless the obligor has a valid reason for not complying with the order. The obligor will document at least five new attempts to find employment on the form each week. The same employer may not be reported more than once per week.

The obligor will include the names, addresses, and the telephone numbers of each of the five employers or businesses with whom the obligor attempted to seek employment and the name of the individual contact to whom the obligor made application for employment or to whom the inquiry was directed.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.25(252B) Reasons for noncompliance of administrative seek employment. Upon verification, certain conditions will be considered valid reasons for noncompliance. At the request of child support services, the obligor will provide verification of any reason for noncompliance with the order when the information is not available to child support services through online sources. Valid reasons for noncompliance and acceptable verification are:

98.25(1) *Receipt of social security, supplemental security income (SSI), or FIP.* Receipt of social security, SSI, or FIP is considered a valid reason for noncompliance when verified by information contained in online sources available to child support services or written verification from the agency providing the benefits.

98.25(2) *Temporary illness or disability.* Temporary illness or disability of the obligor or other household member is considered a valid reason upon receipt of a completed form prescribed by the department verifying the obligor's inability to seek or accept employment.

98.25(3) *High school student.* Attending high school is considered a valid reason upon verification from the high school.

98.25(4) *Incarceration.* Incarceration is considered a valid reason when verified through online information available to child support services or on receipt of verification from the institution.

98.25(5) *Substance use disorder treatment.* Participating in a supervised substance use disorder treatment program that is associated with a treatment center is considered a valid reason upon verification from the treatment center.

98.25(6) *Job training.* Participation in a job-training or job-seeking program through the department of employment services as a result of receiving benefits from the Supplemental Nutrition Assistance Program is considered a valid reason upon receipt of verification from the department of employment services.

98.25(7) *Employment or self-employment.* Employment or self-employment is considered a valid reason upon verification through the employer for those employed or through tax documents or business records for those self-employed.

98.25(8) *Payment of support.* Payment on the account equal to the amounts prescribed for income withholding in accordance with rule 441—98.7(252D) throughout the duration of the seek employment order is considered a valid reason upon verification of payments posted to the Iowa collection and reporting (ICAR) system.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.26(252B) Administrative seek employment method of service. The seek employment order will be served on the obligor by regular mail. Proof of service will be completed according to Rule of Civil Procedure 1.442.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.27(252B) Administrative seek employment order duration of order. The seek employment order will remain in effect for three months from the date of issuance unless child support services determines the obligor has a valid reason for noncompliance as specified at rule 441—98.25(252B), at which time the order becomes unenforceable.

Upon acceptance of the reason for noncompliance, child support services will notify the obligor that the obligor is no longer required to comply with the seek employment order. Upon denial of the reason for noncompliance, child support services will notify the obligor that the obligor will comply with the existing seek employment order. The notice will be filed with the clerk of the district court. If the obligor disputes this decision, the obligor will have recourse through the district court.
[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.28(252B) Setoff against payment owed to a person by a state agency. The department will make a claim pursuant to 701—Chapter 26 against a payment owed to an obligor by a state agency when support is delinquent and the case qualifies for setoff. Any setoff received as the result of a claim against a payment owed to an obligor will be applied to court-ordered support that the department is attempting to collect pursuant to Iowa Code chapter 252B.

98.28(1) *Case selection.* The department will submit periodically a list of obligors who are delinquent at least $50 in support payments to the department of revenue.

98.28(2) *Distribution of setoff amount.* Setoffs will be applied in accordance with rules 441—95.3(252B) and 441—95.4(252B).

98.28(3) *Percentage of payment setoff.* The amount of setoff will be 50 percent of the total payment due the obligor unless the payment results from lottery winnings, from gambling winnings, from sports wagering winnings, or from a payment for a claim under treasurer of state rules on unclaimed property at 781—Chapter 9, in which case the amount of setoff will be 100 percent of the payment. The amount taken will not exceed the delinquent amount owed by the obligor.
[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.29(252B) Setoff against state income tax refund or rebate. The department will make a claim pursuant to 701—Chapter 26 against an obligor's state income tax refund or rebate when support is delinquent and the case qualifies for setoff. Any setoff received as the result of a claim against an obligor's state income tax refund or rebate will apply to support that the department is attempting to collect pursuant to Iowa Code chapter 252B.

98.29(1) *Case selection.* The department will submit periodically a list of obligors who are delinquent at least $50 in support payments to the department of revenue.

98.29(2) *Refunds.* The department will refund any amount incorrectly setoff to the department of revenue or to the obligor pursuant to 701—subrule 26.7(6). The obligor may agree in writing to apply the refund of the incorrect setoff to any other support obligation due in cases where child support services would otherwise refund the setoff directly to the obligor.

98.29(3) *Distribution of setoff amount.* Setoffs will be applied as provided in rule 441—95.3(252B).
[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.30(252B) Offset against federal income tax refund and federal nontax payment. The department will make a claim against an obligor's federal income tax refund or federal nontax payment when delinquent support is owed. For purposes of this offset, delinquent support will include the entire balance of a judgment for accrued support, as provided in Iowa Code section 252B.5(4). Any offset received as the result of a claim against an obligor's federal income tax refund or federal nontax payment will apply to support that child support services is attempting to collect pursuant to Iowa Code chapter 252B.

98.30(1) *Amount of assigned support.* If the delinquent support is assigned to the department, the amount of delinquent support will be at least $150, calculated by combining the assigned delinquent support in all of the obligor's cases in which the assigned delinquent support is at least $50.

98.30(2) *Amount of nonassigned support.* If delinquent support is not assigned to the department, the claim will be made if the amount of delinquent support is at least $500, calculated by combining the nonassigned delinquent support in all of the obligor's cases in which the nonassigned delinquent support is at least $50.

a. The amount distributed to an obligee will be the amount remaining following payment of a support delinquency assigned to the department. The department will distribute to an obligee the amount collected from an offset according to subrule 98.30(9) within the following time frames:

(1) Within six months from the date the department applies an offset amount from a joint income tax refund to the child support account of the responsible person, or within 15 days of the date of resolution of an appeal under subrule 98.30(8), whichever is later, or

(2) Within 30 days from the date the department applies an offset amount from a single income tax refund to the child support account of the responsible person, or within 15 days of the date of resolution of an appeal under subrule 98.30(8), whichever is later.

(3) However, the department is not mandated to distribute until it has received the amount collected from an offset from the federal Department of the Treasury.

b. Federal nontax payment offsets will be applied as provided in rule 441—95.3(252B).

98.30(3) *Notification to federal agency.* The department will, as permitted or specified by federal regulations, submit notification(s) of liability for delinquent support to the federal Office of Child Support Services.

98.30(4) *Preoffset notice and review.* Each obligor who does not have an existing support debt on record with the federal Office of Child Support Services will be sent a preoffset notice in writing, using address information provided to the federal Office of Child Support Services, stating the amount of the delinquent support certified for offset.

a. Individuals whose names were submitted for federal offset who wish to dispute the offset must notify the department in writing within the time period specified in the preoffset notice.

b. Upon receipt of a complaint from the individual disputing the submission for offset, child support services will conduct a review to determine if there is a mistake of fact and respond to the individual in writing within ten days.

98.30(5) *Recalculation of delinquency.* When the records of the department differ from those of the obligor for determining the amount of the delinquent support, the obligor may provide and the department will accept documents verifying modifications of the order, records of payments made pursuant to state law, and will recalculate the delinquency.

98.30(6) *Notification of modification or elimination.* The department will notify the federal Office of Child Support Services, within time frames established by the federal Office of Child Support Services, of any modification or elimination of an amount referred for offset.

98.30(7) *Failure to timely respond.* When an individual does not respond to the preoffset notice within the specified time even though the department later agrees a certification error was made, the individual must wait for corrective action as specified in subrule 98.30(8).

98.30(8) *Offset notice, appeal, and refund.* The federal Department of the Treasury will send notice that a federal income tax refund or federal nontax payment owed to the obligor has been intercepted. When child support services receives information from the federal Office of Child Support Services regarding the offset, or when the individual whose name was submitted for federal offset notifies the department that the individual has received an offset notice, the department will issue to that individual a form prescribed by the department.

a. The individual whose name was submitted for federal offset will have 15 days from the date of the notice to contest the offset by initiating an administrative appeal pursuant to 441—Chapter 2506. Except as specifically provided in this rule, administrative appeals will be governed by 441—Chapter 2506. The issue on appeal will be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.

b. The department will refund the incorrect portion of a federal income tax offset or federal nontax payment offset within 30 days following verification of the offset amount. Verification means a listing from the federal Office of Child Support Services containing the obligor's name and the amount of tax refund or nontax payment to which the obligor is entitled. The date the department receives the federal listing will be the beginning day of the 30-day period in which to make a refund.

c. The department will refund the amount incorrectly set off to the obligor unless the obligor agrees in writing to apply the refund of the incorrect offset to any other support obligation due.

98.30(9) *Application of offsets.* Offsets of federal income tax refunds will be applied to delinquent support only. The department will first apply the amount collected from an offset to delinquent support assigned to the department under Iowa Code chapters 234 and 239B. The department will then apply any amount remaining in equal proportions to delinquent support due individuals receiving nonassistance services.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—98.31(252I) Administrative levy. When there is a delinquency in an amount equal to the ordered support payable for one month, child support services may issue an administrative levy pursuant to Iowa Code chapter 252I and according to Rule of Civil Procedure 1.442.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.32(252J) Referral for license sanction. In the process referred to as license sanction, child support services may refer an individual to a licensing agency for the suspension, revocation, nonissuance, or nonrenewal of a variety of licenses, including but not limited to motor vehicle registrations; driver's licenses; business and professional licenses; and licenses for hunting, fishing, boating, or other recreational activity. In order to be referred to a licensing agency for license sanction, one of the following must apply:

98.32(1) *Delinquent support payments.* An obligor's support payments must be delinquent in an amount equal to the support payment for three months. Child support services will not refer obligors whose support payments are being made under an income withholding order.

98.32(2) *Subpoena or warrant.* An individual must have failed to comply with a subpoena or warrant, as defined in Iowa Code chapter 252J, relating to a paternity or support proceeding. If a subpoena was issued, the individual must have failed to comply with a form prescribed by the department or an Interstate Subpoena as provided in 441—subrule 96.2(1) within 15 days of the issuance of the subpoena, and proof of service of the subpoena was completed according to Rule of Civil Procedure 1.442.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.33(252J) Reasons for exemption from license sanction. Certain conditions will be considered valid reasons for exemption from the license sanction process. Upon verification of these conditions, child support services will bypass, exempt, or withdraw the individual's name from referral to licensing agencies for the purpose of applying a license sanction. When the information to verify the exemption is not available to child support services through online sources, child support services will request, and the individual will provide, verification of the reason for exemption. Valid reasons for exemption for failure to comply with a subpoena or warrant and acceptable verification are those listed in subrules 98.33(2), 98.33(3), 98.33(5), and 98.33(6). Valid reasons for exemption for delinquent support payments and acceptable verification are any of the following:

98.33(1) *Receipt of social security, supplemental security income (SSI) or FIP.* Receipt of social security, SSI, FIP, or county assistance (general relief, general assistance, community services, and veteran's assistance), based upon the eligibility of the obligor, is considered a valid reason for exemption when verified by information contained in online sources available to child support services or written verification from the agency providing the benefits.

98.33(2) *Temporary illness or disability.* Temporary illness or disability of the individual or illness or disability of another household member that requires the presence of the individual in the home as caretaker is considered a valid reason for exemption upon receipt of a completed form prescribed by the department verifying the individual's or household member's inability to work.

98.33(3) *Incarceration.* Incarceration is considered a valid reason for exemption when verified through online information available to child support services or upon receipt of verification from the institution.

98.33(4) *Job training.* Participation in a job-training or job-seeking program through the department of employment services as a result of receiving benefits from the Supplemental Nutrition Assistance Program is considered a valid reason for exemption upon receipt of verification from the department of employment services or verification through online information available to child support services or upon receipt of a written statement from an income maintenance worker.

98.33(5) *Chemical dependency treatment.* Participation in a chemical dependency treatment program that is licensed by the department or the joint commission (TJC) is considered a valid reason for exemption upon receipt of written verification from the professional staff of the program that participation in the program precludes the individual from working.

98.33(6) *Contempt process.* Involvement in a contempt action dealing with support issues is considered a valid reason for exemption from the license sanction process during the pendency of the contempt action.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.34(252J) Notice of potential sanction of license. When an individual meets the criteria for selection, child support services may issue a notice to the individual of the potential sanction of any license held by the individual pursuant to Iowa Code chapter 252J using a form prescribed by the department.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.35(252J) License sanction conference.

98.35(1) *Scheduling of conference.* Upon receipt from an individual of a written request for a conference, child support services will schedule a conference not more than 30 days in the future. At the request of either child support services or the individual, the conference may be rescheduled one time. When setting the date and time of the conference, if notice was sent to an obligor under rule 441—98.34(252J), child support services will request the completion of a form prescribed by the department and other financial information from both the obligor and the obligee as may be necessary to determine the obligor's ability to comply with the support obligation.

98.35(2) *Payment calculation.* If notice was sent to an obligor under rule 441—98.34(252J) during the conference held in compliance with the provisions of Iowa Code section 252J.4, child support services will determine if the obligor's ability to pay varies from the current support order by applying the mandatory supreme court guidelines as contained in 441—Chapter 99, with the exception of 441—subrules 99.4(3) and 99.5(5). If further information from the obligor is necessary for the calculation, child support services may schedule an additional conference no less than ten days in the future in order to allow the obligor to present additional information as may be necessary to calculate the amount of the payment. If, at that time, the obligor fails to provide the required information, child support services will issue a certificate of noncompliance to applicable licensing authorities. If the obligee fails to provide the necessary information to complete the calculation, child support services will use whatever information is available. If no income information is available for the obligee, child support services will determine the obligee's income in accordance with 441—subrules 99.1(2) and 99.1(4). This calculation is for determining the amount of payment for the license sanction process only and does not modify the amount of support obligation contained in the underlying court order.

98.35(3) *Referral for review and adjustment.* If the amount calculated in subrule 98.35(2) meets the criteria for review and adjustment as specified in rule 441—101.4(252B,252H), or administrative modification as specified in rule 441—101.12(252H) and 441—subrules 101.13(1), 101.13(2) and 101.13(6) at the time child support services provides the payment agreement to the obligor, child support services will also provide the obligor with any necessary forms to request a review and adjustment or administrative modification of the support obligation. The payment agreement remains in effect during the review and adjustment or administrative modification process.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.36(252J) License Sanction Payment Agreement. The License Sanction Payment Agreement will require the obligor to pay the lower of the amount calculated in subrule 98.35(2) or the maximum amount payable under an income withholding order as specified in rule 441—98.7(252D).

98.36(1) *Duration of payment agreement.* The License Sanction Payment Agreement signed under this chapter will remain in effect for at least one year from the date of issuance unless child support services determines the obligor has a valid reason for exemption as specified in rule 441—98.33(252J). Except in those cases in which review and adjustment are in process, child support services may, at the end of the

year, begin the process of reviewing the case so that the payment amount continues to accurately reflect the obligor's ability to pay as calculated in subrule 98.35(1).

98.36(2) *Failure to comply.* If at any time following the signing of a payment agreement the obligor fails to comply with all the terms of the agreement, child support services will issue a form prescribed by the department to applicable licensing authorities in accordance with the provisions of Iowa Code chapter 252J.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.37(252J) Staying the process of license sanction due to full payment of support. If the obligor, at any time, pays the total support owed, both current and past due, or an individual complies with the subpoena or warrant, child support services will stay the process, and any form issued by the department will be withdrawn by child support services.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.38(252J) Duration of license sanction. Forms issued by the department will remain in effect until the obligor pays all support owed, both arrears and current; or the obligor enters into a payment agreement with child support services; or the obligor meets one of the criteria for exemption specified at subrules 98.33(1), 98.33(2), and 98.33(4); or the individual complies with the subpoena or warrant.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.39(252B) Procedures for providing information to consumer reporting agencies. Child support services may make information available to consumer reporting agencies regarding the amount of delinquent support owed by a responsible person, but only in cases where the delinquent support exceeds $1,000. However, before child support services will release the information to a consumer reporting agency, the agency must meet the requirements for a nationwide consumer reporting agency under Iowa Code section 252B.9(3)*"j."*

98.39(1) *Request of information.* Agencies may request the information from the department. Requests for information about an individual shall include the individual's name and identifying information such as a social security number or birth date. Agencies may also request a listing of all obligors owing support in excess of $1,000.

98.39(2) *Notice of proposed release of information.* A notice of proposed release of information will be sent to the last-known address of the responsible person 30 calendar days prior to the release of the support arrearage information to a consumer reporting agency. This notice will explain the information to be released and the methods available for contesting the accuracy of the information.

98.39(3) *Contesting proposed release of information.* The responsible person may, within 15 calendar days of the date of the notice of proposed release of information, request a conference with child support services to contest the accuracy of the information to be given to the consumer reporting agency. In contested cases, no referral will be made to the consumer reporting agency until after the amount of overdue support has been confirmed to exceed $1,000.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.40(252B) Difficult-to-collect arrearages. Child support services may refer difficult-to-collect arrearages to a collection entity under contract with child support services or with another state entity. Upon referral, a surcharge, in addition to the support, shall be due and payable by the obligor as provided in Iowa Code chapter 252B.

98.40(1) *Difficult-to-collect arrearage.* A difficult-to-collect arrearage is one based upon a court or administrative order that meets all the following criteria:

a. There is no order for current support and only an arrearage is owing.

b. There has been no payment, except for federal or state tax refund offset payments, in the past three months.

c. There is no valid reason for exemption from the referral and surcharge process. Valid reasons for exemption and acceptable verification are those listed in subrules 98.33(1), 98.33(3), and 98.33(6). Upon verification of those conditions, child support services will bypass or exempt the obligor's arrearages from the referral and surcharge process. When the information to verify the exemption is not available to child

support services through online sources, child support services will request, and the obligor will provide, verification of the reason for exemption.

98.40(2) *Notice of the possibility of referral and surcharge.* Child support services will provide notice of the possibility of a referral and surcharge to the obligor as mandated by Iowa Code chapter 252B. The notice will be provided at least 15 days before child support services sends the notice of referral and surcharge to the obligor, subject to the following:

a. Notification contained in order. When the support order under which the arrearage has accrued contains language advising of statutory provisions for referral and surcharge, no other preliminary notice will be required.

b. Notification issued by child support services. When the support order under which the arrearage has accrued does not contain language regarding the statutory provisions for referral and surcharge, or was entered under a foreign jurisdiction and notification was not included in the support order or provided as a separate written notice, child support services will issue a notice to the obligor pursuant to Iowa Code section 252B.23.

98.40(3) *Notice of referral and surcharge.* Child support services will send notice of a referral and surcharge to the obligor by regular mail to the obligor's last-known address, with proof of service completed according to Rule of Civil Procedure 1.442. The notice will contain all the information mandated by Iowa Code chapter 252B. The notice will be sent at least 30 days before child support services refers the arrearage to the collection entity.

98.40(4) *Contesting the referral and surcharge.* An obligor may contest the referral and surcharge. The right to contest is limited to a mistake of fact, including but not limited to a mistake in the identity of the obligor, a mistake as to whether there was a payment in the three months before the date of the notice specified in subrule 98.40(3), a mistake as to whether an exemption in paragraph 98.40(1)*"c"* applies, or a mistake in the amount of arrearages.

a. An obligor may contest the referral and surcharge by submitting a written request for a review to child support services within 20 days of the date on the notice of referral and surcharge specified in subrule 98.40(3). Upon receipt of a written request for review, child support services will follow the criteria and procedures specified in Iowa Code chapter 252B for resolving the request.

(1) If child support services determines there is a mistake in the identity of the obligor, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.40(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, child support services will issue a written notice to the contestant or obligor of the determination and not refer the arrearages. If child support services later determines an arrearage may be subject to referral, it will issue a new notice as provided in subrule 98.40(3).

(2) If child support services determines there was a mistake in the amount of arrearages, but the corrected amount of arrearages will still be referred, or if child support services determines there is no mistake of fact, child support services will issue a written notice of the determination of the review to the obligor by regular mail to the last-known address of the obligor. The notice will include the amount of the arrearages that will be referred and the surcharge that will be assessed. The notice will also include information on requesting an additional review by the department, and on requesting a judicial hearing.

b. An obligor may contest the notice of determination of review by submitting a written request for an additional review by the department within 20 days of the date of the notice of determination of the review issued under paragraph 98.40(4)*"a."* Upon receipt of the written request for additional review, child support services will review the facts of the case.

(1) If the department determines a mistake in the identity of the obligor has occurred, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.40(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, the department will issue a written notice to the contestant or obligor of the determination and the arrearages will not be referred. If child support services later determines an arrearage may be subject to referral, it will issue a new notice as provided in subrule 98.40(3).

(2) If the department determines that there was a mistake in the amount of the arrearage but the corrected amount of arrearages will still be referred, or if there is no mistake of fact, the department will

send a written notice of the additional review determination to the obligor by regular mail to the last-known address of the obligor. The notice will include the amount of the arrearage that will be referred and the surcharge that will be assessed. The notice will also include information on requesting a judicial hearing.

c. Following the issuance of a notice of determination of a review under paragraph 98.40(4)*"a,"* or issuance of a notice of determination of an additional review under paragraph 98.40(4)*"b,"* the obligor may request a district court hearing. The obligor will make a request by sending a written request for a hearing to child support services within ten days of the date of the department's written determination of the review, or within ten days of the date of child support services' written determination of an additional review, whichever is later. Procedures for a district court hearing are specified in Iowa Code chapter 252B.

d. Child support services will not refer arrearages and assess a surcharge until after completion of any review, additional review or judicial hearing process.

98.40(5) *Referral and surcharge.*

a. If the obligor has not paid the arrearage, has not contested the referral, or if, following child support services review, the department's additional review, and any judicial hearing, child support services, or court does not find a mistake of fact, the arrearage will be referred to the collection entity.

b. The amount of the arrearage referred will be the amount that is unpaid as of the date of the referral. The amount of the surcharge will be an amount equal to the amount of the arrearage unpaid as of the date of the referral, multiplied by the percentage specified in the contract with the collection entity.

c. Child support services will file a notice of the surcharge with the clerk of the district court in the county in which the underlying support order is filed.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.41(252B) Enforcement services by private attorney entitled to state compensation. An attorney licensed to practice law in Iowa may utilize judicial proceedings to collect support, at least a portion of which is assigned support, and be entitled to compensation by the state as provided in Iowa Code chapter 252B.

98.41(1) *Eligible cases.* To be eligible for attorney services with compensation under this rule, a case must meet all of the following:

a. Child support services is providing services under Iowa Code chapter 252B.

b. The current support obligation is terminated and only arrearages are due under the administrative or court order.

c. There has been no payment under any order in the case for at least a 12-month period prior to the provision of the notice from the attorney to child support services under paragraph 98.41(1)*"f."*

d. At least a portion of the arrearages due under any order in the case is assigned to the state because cash assistance was paid under Iowa Code chapter 252B.

e. The case does not have any of the following characteristics:

(1) There has been a finding of good cause or other exception pursuant to Iowa Code section 252B.3.

(2) A portion of the arrears is assigned to another state because of public assistance provided by that state.

(3) Another attorney has already notified child support services of the intent to initiate a judicial proceeding to collect support due under any order in the same case under this rule, and either the time to receive the collection has not expired or child support services has not received a notice from the other attorney that the judicial proceeding has concluded prior to the expiration of the time period.

(4) If the notice from the attorney under paragraph 98.41(1)*"f"* specifies contempt of court as the judicial proceeding, and child support services has generated an administrative seek employment order to the obligor under Iowa Code section 252B.21 less than nine months prior to the date on the notice from the attorney.

(5) The case or arrearages have been referred by child support services to a collection entity under Iowa Code section 252B.5(3) less than nine months prior to the date on the notice from the attorney.

(6) The obligor has filed for bankruptcy and collection activities are stayed.

(7) The notice from the attorney under paragraph 98.41(1)*"f"* lists a specific judicial proceeding and child support services has already initiated the same type of proceeding in court.

(8) The case has been referred to the U.S. Attorney's office and is still pending at that office.

f. The attorney has provided written notice to the central office of child support services, and to the last-known address of the obligee of the intent to initiate a specified judicial proceeding to collect support on any identified court or administrative order involving the obligor and obligee in the case.

g. The attorney has provided documentation of insurance to child support services as mandated by Iowa Code chapter 252B.

h. The collection must be received by the collection services center within 90 days of the notice from the attorney in paragraph 98.41(1)*"f,"* or within a subsequent 90-day extension period.

98.41(2) *Procedure.*

a. To begin the process under this rule, the attorney shall submit the following to the department at least 30 days prior to initiating the specified judicial proceeding:

(1) A dated, written statement that lists the specific judicial proceeding that the attorney intends to initiate, any court or administrative order under which the arrearages accrued identified by the order number, and the names of the obligor and obligee.

(2) Documentation that the attorney is insured as mandated by the statute. Documentation shall be either a copy of the attorney's policy from the insurer, or a letter from the insurer verifying insurance coverage as mandated by the statute.

(3) Documentation that the attorney is licensed to practice law in Iowa.

b. Child support services will mail a response to the attorney within ten days of receipt of the notice from the attorney. All of the following will apply to the child support services response:

(1) If the case meets the requirements of this rule, the notice will list the case number, any order numbers, the judicial proceeding specified by the attorney, the balance due the state of Iowa, the balance due an obligee, and the date that is 90 days from the date of the notice from the attorney. The notice will also contain a statement that any compensation due the attorney as a result of application of this rule will be calculated on the amount of support credited to arrearages due the state at the time the support paid as a result of the judicial proceeding is received by the collection services center. The notice will also contain a statement that any support collected will be disbursed in accordance with federal requirements, and any support due the obligee will be disbursed to the obligee prior to disbursement to the attorney as compensation.

(2) If the case does not meet the requirements of this rule, the notice will list the case number, any order number, and the reason the case does not meet the requirements.

c. If the case is eligible under this rule, the attorney may initiate judicial proceedings after 30 days after providing the notice to child support services in paragraph 98.41(2)*"a."* Iowa Code chapter 252B defines "judicial proceedings."

d. The attorney may extend the time to complete the judicial proceeding or to allow for receipt of the collection by the collection services center by submitting a notice requesting a 90-day extension to the address in paragraph 98.41(2)*"a."* This or any subsequent notice must be received by child support services before expiration of the current 90-day time frame. Child support services will acknowledge receipt of the subsequent notice and list on the acknowledgment the date that is 90 days from the date of the attorney's subsequent notice.

98.41(3) *Collection and payment to attorney.*

a. Upon compliance with the requirements of Iowa Code chapter 252B and this rule, the attorney will be entitled to compensation from the state as provided for in this rule.

b. Upon receipt of a file-stamped copy of a court order that identifies the amount of support collected as a result of the judicial proceeding and that does not order the payment of attorney fees by the obligor, and the receipt of the collection by the collection services center, all the following apply:

(1) Iowa Code chapter 252B specifies the formula to calculate the compensation due the attorney from the state. Child support services will calculate the compensation due the attorney based upon the amount of support that is credited to arrearages due the state at the time the collection is received by the collection services center. After calculating the amount due the attorney, child support services will reduce the amount due the attorney by the amount of any penalty or sanction imposed upon the state as a result of any other judicial proceeding initiated by that attorney under Iowa Code chapter 252B. Child support services will send the attorney a notice of the amount of the compensation due from the state.

(2) The collection services center will disburse any support due an obligee prior to payment of compensation to the attorney.

(3) Child support services will not authorize disbursement of compensation to the attorney until the later of 30 days after receipt of the collection and the file-stamped copy of the order, or resolution of any timely appeal by the obligor or obligee.

(4) The amount of compensation due the attorney is subject to judicial review upon application to the court by the attorney.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

441—98.42(17A) Right of appeal.

98.42(1) Under this chapter, an administrative appeal pursuant to 441—Chapter 2506 will be limited to the following issues:

a. A claim or offset is contested as provided in subrule 98.30(8) by a person's alleging a mistake of fact.

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

98.42(2) A hearing will not be granted under 441—Chapter 2506 when the appellant has a complaint about child support services enforcement matters other than those described in this rule.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—98.43(17A) Appeal record. The record in an administrative appeal under this rule will include, in addition to those materials specified in Iowa Code section 17A.12(6), the notice of appeal and the verbatim record of the hearing.

[**ARC 8964C**, IAB 2/19/25, effective 4/1/25]

These rules are intended to implement Iowa Code sections 96.3, 252B.9, 252B.21, 252B.5, 252B.3, 252B.4, and 421.65; chapters 252D, 252E, 252I, 252J, and 17A; and 15 U.S.C. Section 1673(b).

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CHAPTER 99
CHILD SUPPORT GUIDELINES

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—99.1(234,252B,252H) Income considered. Child support services will consider all regularly recurring income of both legal parents to determine the amount of the support award in accordance with the child support guidelines prescribed by the Iowa Supreme Court. Spousal support will be considered as specified in the Iowa Supreme Court guidelines and prior obligation spousal support actually paid or received will be calculated in the same manner as the deductions for support in subrule 99.2(1). These rules on child support guidelines will not apply if child support services is determining the support amount by a cost-of-living alteration as provided in Iowa Code chapter 252H, subchapter IV.

99.1(1) *Exempt income.* The following income of the parent is exempt in the establishment or modification of support:

a. Income received by the parent under the family investment program (FIP).

b. Income or other benefits derived from public assistance programs funded by a federal, state, or local governmental agency or entity that are listed in 441—41.27(239B) as exempt from consideration in determining eligibility under FIP.

c. Income such as child support, social security dependent benefits received by a parent for a child because of the other parent's disability, and veteran's dependent benefits received by a parent on behalf of a child.

d. Stepparent's income.

e. Income of a guardian who is not the child's parent.

f. Income of the child's siblings.

g. Earned income tax credit.

99.1(2) *Determining income.* Any of the following may be used in determining a parent's income for establishing or modifying a support obligation:

a. Income reported by the parent in a financial statement.

b. Income established by any of the following:

(1) Income verified by an employer or other source of income.

(2) Income reported to the department of workforce development.

(3) For a public assistance recipient, income reported to the department of health and human services caseworker assigned to the public assistance case.

(4) Other written documentation that identifies income.

c. Income as determined through occupational wage rate information published by the Iowa workforce development department or other state or federal agencies.

d. The median income for parents on the child support services caseload, calculated annually.

e. Social security dependent benefits. Social security dependent benefits paid for a child because of a parent's disability will be included in the disabled parent's income. Social security dependent benefits paid for a parent due to the other parent's disability will be included in the receiving parent's income.

99.1(3) *Verification of income.* Verification of income and allowable deductions from each parent will be requested.

a. Verification of income may include but is not limited to the following:

(1) Federal and state income tax returns.

(2) W-2 statements.

(3) Pay stubs.

(4) Signed statements from an employer or other source of income.

(5) Self-employment bookkeeping records.

(6) Award letters confirming entitlement to benefits under a program administered by a government or private agency such as social security, veterans' or unemployment benefits, military or civil service retirement or pension plans, or workers' compensation.

b. Cases in which the information or verification provided by a parent is questionable or inconsistent with other circumstances of the case may be investigated. If the investigation does not reveal any inconsistencies, the financial statement and other documentation provided by the parent will be used to establish income.

c. If discrepancies exist in the financial statement provided by the parent and additional income information is not available, child support services may:

(1) Request a hearing before the court if attempting to establish a support order through administrative process.

(2) Conduct discovery if a parent places the matter before the court by answering a petition or requesting a hearing before the court.

(3) When attempting to establish a default order, provide the court with a copy of the parent's financial information and the reasons the information may be questionable.

d. If child support services is unable to obtain verification of a parent's income, the financial statement provided by the parent may be used to establish support.

99.1(4) *Use of occupational wage rate information or median income for parents on the child support services caseload.* Child support services will use occupational wage rate information or median income for parents on the child support services caseload to determine a parent's income when the parent has failed to return a completed financial statement when requested, and when complete and accurate income information from other readily available sources cannot be secured. If a parent's most recent residential address is in Iowa, child support services will use Iowa workforce development regional data to determine income. If a parent's most recent residential address is in another state, the District of Columbia, or Puerto Rico, child support services will use wage data from the place of the parent's most recent residence to determine income. For all other cases, child support services will use Iowa statewide occupational wage rate or median income for parents on the child support services caseload to determine income.

a. Occupation known. When child support services can reasonably ascertain the current or last-known occupation of a parent, child support services will use occupational wage rate information to determine income. Wage rate information will be converted to a monthly amount in accordance with subrule 99.3(1).

b. Occupation unknown. When child support services cannot reasonably ascertain the current or last-known occupation of a parent, child support services will determine the income of a parent using the median income amount for parents on the child support services caseload, based upon the parent's most recent residential address.

99.1(5) *Self-employment income.* A self-employed parent's adjusted gross income, rather than the net taxable income, will be used in determining net income. The adjusted gross income will be computed by deducting business expenses involving actual cash expenditures that affect the actual dollar income of the parent.

a. A person is self-employed when the person:

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

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

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

b. In calculating net income from self-employment, child support services will deduct only those items allowed by the child support guidelines. Amounts from a prior period claimed as net losses will not be allowed as deductions.

c. Net profits from self-employment may be determined through a review of self-employment bookkeeping records, sales and expenditure records, quarterly reports filed with the IRS, previous year's federal or state income tax returns, or other documentation. The parent must provide records of bookkeeping, sales, and expenditures for the most recent 12-month period or, if the self-employment is less than 12 months old, for the period since the self-employment began.

99.1(6) *Fluctuating income.* A person has a fluctuating income when the calculated gross income or the adjusted gross income, as defined in subrule 99.1(5), for the current year varies from the gross or adjusted gross income of the previous year by more than 20 percent.

a. If requested, child support services will average the income of a person whose income fluctuated because the nature of the person's occupation is of a type that normally experiences fluctuations in income.

b. In determining a person's average income, the following procedures will be used:

(1) For non-self-employed persons, child support services will estimate the gross income for the current year and add the amount to the gross income from relevant years that would accurately depict fluctuations in the person's income. Child support services will divide this sum by the number of years added, prior and current, to arrive at an average gross annual income. Child support services will divide the average gross annual income by 12 to arrive at the person's average gross monthly income.

(2) For income from self-employment, child support services will compute the adjusted gross annual income as defined in subrule 99.1(5) for the relevant years that would accurately depict fluctuations in the person's income. Child support services will use the adjusted gross annual income to compute the average adjusted gross monthly income in the same manner as the computation of average gross monthly income for a non-self-employed person.

[**ARC 8965C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—99.2(234,252B) Allowable deductions. The deductions specified in the Iowa Supreme Court child support guidelines will be allowed when determining the amount of income subject to application of the guidelines. The parent claiming the deduction must provide the documentation necessary for computing allowable deductions. When applying the deductions specified in the Iowa Supreme Court guidelines, the following will also apply:

99.2(1) In determining the amount of child support actually paid pursuant to a prior court or administrative order, the date of the original court or administrative order, rather than the date of any modifications, will determine whether it is a prior order. Support paid under an order established subsequent to the order being modified will not be deducted. All support payments will be verified before being allowed as a deduction. Child support services will calculate deductions for support as follows:

a. If the obligation is one year old or older, child support services will add together all verified amounts paid during the past 12 months preceding the current month up to the total of the current support obligation that accrued during this 12-month period, and divide by 12. All amounts collected will be included, regardless of the source.

b. If the support obligation is less than one year old, child support services will add together the verified amounts paid since the obligation began up to the total of the current support obligation that accrued during this period, and divide by the number of months that the obligation has existed.

c. When a parent has more than one prior support order, child support services will calculate the allowable deduction for each obligation separately, and then add the amounts together to determine the parent's total allowable deduction.

99.2(2) Health insurance premium costs will be verified before being allowed as a deduction.

99.2(3) A qualified additional dependent deduction will be allowed for dependents of the custodial or noncustodial father or mother, whether in or out of the parent's home. The father may establish the deduction by providing written verification of a legal obligation to the child through one of the actions enumerated in the guidelines. The mother may establish the deduction by providing written verification of a legal obligation to the child, including a written statement by the mother or a birth certificate.

99.2(4) All cash medical support payments for other children, not in the pending matter, will be verified before being allowed as a deduction and will be calculated in the same manner as the deductions for support in subrule 99.2(1).

[**ARC 8965C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—99.3(234,252B) Determining net income. Unless otherwise specified in these rules, child support services will determine net income as prescribed by the Iowa Supreme Court guidelines.

99.3(1) *Calculating net income.* All allowable income and allowable deductions will be expressed in monthly amounts. Income and corresponding deductions received at a frequency other than monthly

will be converted to equivalent monthly amounts by multiplying the income and corresponding deductions received on a weekly basis by 4.33, on a biweekly basis by 2.17, and on a semimonthly basis by 2.

99.3(2) *Estimating net income.*

a. The estimated net income of a parent will be 80 percent of the reported income or the estimated income as determined from occupational wage rate information or derived from the median income of parents on the child support services caseload, as appropriate, to account for an estimate of the Iowa Supreme Court guidelines deductions for federal and state taxes and Social Security and Medicare taxes. The parent will also be entitled to additional deductions allowed by the guidelines when the information to calculate these deductions is readily available through automated or other sources.

b. The net income of a parent will be estimated under the following conditions:

(1) Gross earned income information was obtained from a source that did not provide itemized deductions allowed by the mandatory support guidelines.

(2) Occupational wage rate information or median income of parents on the child support services caseload was used to determine a parent's income.

[**ARC 8965C**, IAB 2/19/25, effective 4/1/25]

441—99.4(234,252B) Applying the guidelines.

99.4(1) *Applying the guidelines.* Child support services will use the child support guidelines schedule as prescribed by the Iowa Supreme Court only for the number of children for whom support is being sought sharing the same two legal parents.

Exception: For foster care recovery cases, the guidelines schedule will be used as set forth in subrule 99.5(4).

99.4(2) *Establishing current support.*

a. Calculation. Child support services will calculate the amount of support as prescribed by the Iowa Supreme Court guidelines. Round amount of support to the nearest whole dollar.

b. Additional factors.

(1) In all cases other than foster care, child support services will establish current support payable in monthly frequencies.

(2) In foster care cases, child support services may establish current support payable in monthly or weekly frequencies. To establish a weekly amount, child support services will divide the figure in paragraph 99.4(2)*"a"* by 4.33 and round to the nearest whole dollar.

(3) If the court orders joint (equally shared) physical care of a child or split or divided physical care of multiple children, child support services will calculate current support according to the Iowa Supreme Court guidelines for each parent assuming the other is the custodial parent. If a child begins receiving family investment program (FIP) benefits or if foster care funds are expended, an offset of the two amounts as a method of payment will be disallowed.

(4) The amount of support will be zero if the noncustodial parent's only income is Supplemental Security Income paid pursuant to 42 U.S.C. 1381a (as amended to August 1, 2024).

c. Child care expense add-on. When requested by a parent and if applicable, child support services will calculate the amount of the child care add-on as prescribed by the Iowa Supreme Court guidelines.

(1) Actual child care expenses will be verified by a copy of the custodial parent's federal or state income tax return or by a signed statement from the persons or agencies providing the child care showing the total expenses and the time period the expenses represent. The child care expenses must be reasonably expected to continue.

(2) If the child care expense verification submitted represents a period that is less than 12 months, child support services will convert the expenses provided to an annual expense amount for the calculation.

(3) If the child care expense verification submitted shows varying levels of care during the year, such as full-time summer care and part-time care before and after school during the school year, child support services will average the applicable expenses to determine an annual expense amount for the calculation.

(4) Child support services will round the calculated amount of the child care add-on to the nearest whole dollar.

(5) Any child care add-on recommended by child support services will end on the first date that the next periodic support payment becomes due after the youngest child's thirteenth birthday. Child support

services may recommend an earlier end date if the custodial parent provides a date that child care expenses are reasonably expected to end prior to the youngest child's thirteenth birthday.

99.4(3) *Establishing accrued support debt amount.*

a. Support debt created. The payment of public assistance to or for the benefit of a dependent child or a dependent child's caretaker creates an accrued support debt due and owing by the child's parent to the department. The amount of the accrued support debt is based on the period of time public assistance payment or foster care funds were expended, but is not created for the period of receipt of public assistance on the parent's own behalf for the benefit of the dependent child or the child's caretaker.

b. Calculating accrued support debt. Child support services will calculate the accrued support debt as follows:

(1) For FIP benefits, child support services will use the period for which FIP was paid during the 36 months preceding the date the notice of support debt is prepared or the date the petition is filed. For foster care assistance, child support services will use the three-month period for which foster care assistance was paid prior to the date the initial notice to the noncustodial parent of the amount of support obligation is prepared, or the date a written request for a court hearing is received, whichever is earlier.

(2) Child support services will exclude periods the noncustodial parent received public assistance as a part of this eligible group.

(3) Child support services may extend the period to include any additional periods public assistance is expended prior to the entry of the order.

(4) Child support services will calculate the amount of the obligation by using the current net income of both parents, the guidelines in effect at the time the order is entered, and the number of children of the noncustodial parent who were receiving public assistance for each month for which accrued support is sought.

(5) Child support services will calculate the total amount of the FIP support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount, excluding any applicable child care add-on amount.

(6) Child support services may calculate the total amount of the foster care support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount, excluding any applicable child care add-on amount, and will adjust this amount for weeks in which no foster care benefits were paid.

c. Establishing the accrued support repayment amount.

(1) In cases other than foster care, child support services will establish the repayment amount as follows:

1. When there is an ongoing obligation, the monthly repayment amount will be 10 percent of the ongoing amount, including any child support, child care add-on and cash medical support ordered, unless the noncustodial parent agrees to a higher amount.

2. When the order does not include ongoing support, the monthly repayment amount will be the same as the amount for ongoing child support that would have been due if such an obligation had been established. However, when all of the children for whom accrued support debt is sought are residing with the noncustodial parent, the monthly repayment amount will be set at 10 percent of this amount.

(2) In foster care cases, child support services will establish the repayment amount in the same manner as subparagraph 99.4(3)*"c"*(1), but may establish weekly amounts and if the order does not include ongoing support, the repayment amount will be set at 10 percent of the amount for ongoing child support that would have been due if such an obligation had been established.

99.4(4) *Children in nonparental homes or foster care.* The parents of a child in a nonparental home or in foster care are severally liable for the support of the child. A support obligation will be established separately for each parent.

a. Parents' location known. When the location is known for both parents having a legal obligation to provide support for their children, the income of both parents will be used to determine the amount of ongoing support in accordance with the child support guidelines.

(1) Calculating support amount. There will be a separate calculation of each parent's child support amount, regardless of whether the parents are married and living together, or living separately. Each

calculation will assume that the parent for whom support is being calculated is the noncustodial parent and the other parent is the custodial parent.

(2) Prior orders. If only one parent is paying support under a prior order for the children for whom support is being calculated, the amount of support paid will not be deducted from that parent's net monthly income in computing the support amount for the other parent.

b. One parent's location unknown. When the location of one parent is not known, procedures will be initiated to establish a support order against the parent whose location is known in accordance with the mandatory support guidelines as follows:

(1) The parent whose location is known will be considered the noncustodial parent and that parent's income will be used to calculate child support.

(2) The income of the parent whose location is unknown will be determined by using the estimated median income for parents on the child support services caseload and that parent will be considered the custodial parent in calculating child support.

c. When one parent is deceased or has had parental rights terminated, the method used to calculate support when one parent's location is not known will be used. The parent who is deceased or has had parental rights terminated will be considered the custodial parent with zero income.

99.4(5) *Adjustment for extraordinary visitation or parenting time.* Child support services will calculate an extraordinary visitation or parenting time credit as specified in the Iowa Supreme Court guidelines. The credit will not reduce the child support below the amount required by the Iowa Supreme Court guidelines.

The extraordinary visitation adjustment or parenting time credit will be given if all of the following apply:

a. There is an existing order for the noncustodial parent that meets the criteria for extraordinary visitation or parenting time in excess of 127 overnights per year on an annual basis for the child for whom support is sought. The order granting visitation or parenting time can be a different order than the child support order. If a controlling order is determined pursuant to Iowa Code chapter 252K and that controlling support order does not meet the criteria for extraordinary visitation or parenting time, there is another order that meets the criteria.

b. The noncustodial parent has provided child support services with a file-stamped or certified copy of the order.

c. The court has not ordered equally shared physical care.

99.4(6) *Establishing medical support.* Child support services will calculate medical support as required by Iowa Code chapter 252E and the Iowa Supreme Court guidelines. The cost of the health insurance premium for the child is added to the basic support obligation and prorated between the parents as provided in the Iowa Supreme Court guidelines and the parent ordered to provide health insurance must provide verification of this expense or anticipated expense.

[**ARC 8965C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—99.5(234,252B) Deviation from guidelines.

99.5(1) *Criteria for deviation.* The court will not vary from the amount of child support that would result from application of the guidelines without a written finding as required by the Iowa Supreme Court guidelines.

99.5(2) *Supporting financial and legal documentation.*

a. The party requesting a deviation from the guidelines must provide supporting documentation. The supporting documentation must include an itemized list identifying the amount and nature of each adjustment requested. Failure to provide supporting documentation for a request for deviation will result in a denial of the request.

b. Legal documents prepared for the court's approval, such as stipulations and orders for support, will include language to identify the following:

(1) The amount of support calculated under the guidelines without allowance for deviations.

(2) The reasons for deviating from the guidelines.

(3) The amount of support calculated after allowing for the deviation.

99.5(3) *Depreciation.* A parent may request a deduction for depreciation of machinery, equipment, or other property used to earn income. Straight-line depreciation will be the only type of depreciation that will be allowed as a deduction. Child support services will allow the straight-line depreciation amount as a deduction if the parent provides documentation from a tax preparer verifying the amount of straight-line depreciation being claimed. Straight-line depreciation is computed by deducting the property's estimated salvage value from the cost of the property, and deducting that figure in equal yearly amounts over the period of the property's remaining estimated useful life.

99.5(4) *Foster care case.* In a foster care case, child support services may deviate from the guidelines by applying a 30 percent flat rate deduction for parents who provide financial documentation. The flat rate deduction represents expenses under the case permanency plan and financial hardship allowances or other circumstances contemplated in Iowa Code section 234.39.

Child support services will calculate the support obligation of the parents of children in foster care when the parents have a legal obligation for additional dependents in the home, as follows: The support obligation of each parent will be calculated by allowing all deductions the parent is eligible for under the child support guidelines as provided in rule 441—99.2(234,252B) and by using the guidelines schedule corresponding to the sum of the children in the home for whom the parent has a legal obligation and the children in foster care. The calculated support amount will be divided by the total number of children in foster care and in the home to compute the support obligation of the parent for each child in foster care.

99.5(5) *Negotiation of accrued support debt.* Child Support Services may negotiate with a parent to establish the amount of accrued support debt owed to the department. In negotiating accrued support, the state does not represent the custodial parent. The custodial parent may intervene at any time prior to the filing of the order to contest the amount of the debt or request the entry of a judgment in the parent's behalf that may otherwise be relinquished through negotiation or entry of a judgment.

[**ARC 8965C**, IAB 2/19/25, effective 4/1/25]

441—99.6(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[**ARC 8965C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 234.39, 252B.3, 252B.5, 252B.7A, and 598.21(4).

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CHAPTER 100
ESTABLISHMENT OF PATERNITY AND SUPPORT

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—100.1(598,600B) Definitions.

"Disestablishment" means paternity that is legally overcome under the conditions specified in Iowa Code section 600B.41A, 232.3A, or 598.21E.

"Nonrequesting parent" means a parent who is not filing a petition to overcome paternity.

"Requesting parent" means a parent who files a petition to overcome paternity.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.2(252A) Temporary support. If a court ordered a putative father to pay temporary support before entering an order making a final determination of paternity under Iowa Code section 252A.6A, but then the court determines that the putative father is not the legal father and enters an order terminating the temporary support, all the following apply:

100.2(1) *Satisfaction of accrued support.* Upon receipt of a file-stamped copy of the order terminating the support order, child support services will take the following actions concerning unpaid support assigned to the department:

a. Child support services will satisfy only unpaid support assigned to the department.

b. Child support services will ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver or notice, child support services is not prevented from satisfying amounts due the department.

c. Child support services will prepare the required documents to satisfy any amounts owed the department and will file them with the appropriate district court.

100.2(2) *Previously collected moneys.* Child support services will not return any moneys previously paid on the temporary support judgment.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.3(252F) When paternity may be established administratively. Child support services may seek to administratively establish paternity and accrued or accruing child support and medical support obligations against an alleged father when the conditions specified in Iowa Code chapter 252F are met.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.4(252F) Mother's certified statement. Before initiating an action under Iowa Code chapter 252F, child support services may obtain a form prescribed by the department or a similar document from the child's caretaker. Child support services will obtain a form prescribed by the department from the child's mother certifying, in accordance with Iowa Code section 622.1, that the man named is or may be the child's biological father. Government records, including but not limited to an application for public assistance, that substantially meet the requirements of Iowa Code section 622.1 may also be used. In signing a form prescribed by the department, the mother acknowledges that child support services may initiate a paternity action against the alleged father. The mother must sign and return the form prescribed by the department to child support services within ten days of the date of child support services' request.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.5(252F) Notice of alleged paternity and support debt. Following receipt of a form prescribed by the department or government records, including but not limited to an application for public assistance, that substantially meet the requirements of Iowa Code section 622.1, child support services will serve a notice of alleged paternity and support debt as provided in Iowa Code section 252F.3.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.6(252F) Conference to discuss paternity and support issues. A party may request a conference as provided in Iowa Code section 252F.3(1) with the office that issued the notice to discuss paternity establishment and the amount of support the father may be required to pay.
[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.7(252F) Amount of support obligation. Child support services will determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.
[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.8(252F) Paternity contested. The alleged father may contest the paternity establishment by submitting, within 20 calendar days after service of the notice upon him, as provided in rule 441—100.5(252F), a written statement contesting paternity to the address of child support services as set forth in the notice. The mother may contest paternity establishment by submitting, within 20 calendar days after child support services mailed her notice of the action or within 20 calendar days after the alleged father is served with the original notice, whichever is later, a written statement contesting paternity to the address of child support services as set forth in the notice. When paternity is contested, or at child support services' initiative, child support services will issue ex parte administrative orders requiring the alleged father, the mother and the child to submit to paternity testing. If the mother and child or children previously submitted blood or genetic specimens in a prior action to establish paternity against a different alleged father, the previously submitted specimens and prior results, if available, may be used for testing in this action.
[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.9(252F) Paternity test results challenge. Either party or child support services may challenge the results of the paternity test by filing a written notice with the district court within 20 calendar days after child support services issues or mails the paternity test results to the parties. When a party challenges the paternity test results, and requests an additional paternity test, child support services will order an additional blood or genetic test, if the party requesting the additional test pays for the additional testing in advance. If the party challenges the first paternity test results, but does not request additional tests, child support services may order additional blood or genetic tests.
[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.10(252F) Agreement to entry of paternity and support order. If the alleged father admits paternity and reaches agreement with child support services on the entry of an order for support, the father may acknowledge his consent on a form prescribed by the department. If the mother does not contest paternity within the allowed time period or if the mother waives the time period for contesting paternity, child support services may file the form, if applicable, and Administrative Paternity Order with the court in accordance with Iowa Code section 252F.6.
[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.11(252F) Entry of order establishing paternity only. If a party requests a court hearing on support issues and paternity is not contested, or if paternity was contested but neither party filed a timely challenge of the paternity test results, child support services will prepare an order establishing paternity and reserving the support issues for determination by the court. Child support services will present the order and other documents supporting the entry of the ex parte paternity-only order to the court for review and approval prior to the hearing on the support issues.
[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.12(252F) Exception to time limit. Child support services may accept and respond to written requests for court hearings beyond the time limits allowed in this part.
[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.13(252F) Genetic test costs assessed.

100.13(1) *Paternity established.* If genetic testing of an alleged father is conducted and that man is established as the child's father, child support services will assess the costs of the genetic testing to the father who denied paternity and enter an order for repayment of these costs.

100.13(2) *Paternity not established.* If genetic testing of an alleged father is conducted and that man is not established as the child's father, the costs of the genetic testing will not be assessed to any of the parties.

100.13(3) *Results contested.* If the results of the genetic testing are timely challenged and the challenging party requests additional testing, the party contesting the results must advance the cost of the additional testing. If the challenging party does not advance payment for the additional testing, child support services will certify the case to district court.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.14(598,600B) Communication between parents. When a parent who has filed a petition to disestablish paternity requests assistance from child support services in contacting the other parent, child support services will take the following actions if services are being provided by child support services, the location of the nonrequesting party is known, and child support services has been provided a copy of the petition to disestablish paternity:

100.14(1) *Written contact.* Child support services will send written notification to the nonrequesting parent of the requesting parent's desire to disestablish paternity and of the requesting parent's whereabouts. The notice will state that the nonrequesting parent may cooperate in this action by filing a statement of the nonrequesting parent's current address or the name and address of the nonrequesting parent's attorney in the court file, or may contact the requesting parent with this information.

100.14(2) *Notification of requesting parent.* Child support services will provide notification to the requesting party that contact was made with the nonrequesting party and that the nonrequesting parent may file a statement in the court file or may contact the requesting parent directly.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.15(598,600B) Continuation of enforcement. Child support services will continue all enforcement actions to collect current and accrued support as ordered until child support services receives a file-stamped copy of the order disestablishing paternity.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.16(598,600B) Satisfaction of accrued support.

100.16(1) *Disestablishment orders entered before May 21, 1997.* Upon receipt of a file-stamped copy of an order disestablishing paternity that was entered before May 21, 1997, child support services will take the following actions concerning unpaid support assigned to the department:

a. Child support services will satisfy only unpaid support assigned to the department and only if:

(1) For actions under Iowa Code section 600B.41A or 232.3A, blood or genetic testing was done and a guardian ad litem was appointed for the child.

(2) For actions under Iowa Code section 598.21E, the written statement was filed and a guardian ad litem was appointed for the child.

b. Child support services will ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, child support services is not prevented from satisfying amounts due the department.

c. Child support services will prepare the required documents to satisfy any amounts owed the department and will file them with the appropriate district court. If the court later determines that paternity was incorrectly disestablished, child support services may attempt to reinstate and enforce the prior judgment.

100.16(2) *Disestablishment orders entered on or after May 21, 1997.* Upon receipt of a file-stamped copy of an order disestablishing paternity that was entered on or after May 21, 1997, child support services will take the following actions concerning unpaid support:

a. If the order also contains a provision satisfying unpaid support, child support services will adjust its records to show unpaid support is paid.

b. If the order does not contain a provision satisfying unpaid support, child support services will satisfy only unpaid support assigned to the department. Child support services will notify the party who petitioned the court for disestablishment that this is the only support child support services can satisfy.

(1) Child support services will ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver notice, child support services is not prevented from satisfying amounts due the department.

(2) Child support services will prepare the required documents to satisfy any amounts owed the department and will file them with the appropriate court. If the court later determines that paternity was incorrectly disestablished, child support services may attempt to reinstate and enforce the prior judgment.

100.16(3) *Termination of paternity.* If the court entered an order dismissing a disestablishment of paternity action on or before May 21, 1997, this subrule applies. Upon receipt of a file-stamped copy of an order terminating paternity under the requirements of Iowa Code section 600B.41A, child support services will take the following actions concerning unpaid support assigned to the department:

a. Child support services will satisfy only unpaid support assigned to the department.

b. Child support services will ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, child support services is not prevented from satisfying amounts due the department.

c. Child support services will prepare the required documents to satisfy any amounts owed the department and will file them with the appropriate district court. If the court later determines that paternity was incorrectly terminated, child support services may attempt to reinstate and enforce the prior judgment.

100.16(4) *Previously collected moneys.* Child support services will not return any moneys previously paid on the judgment.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.17(252C) Establishment of an administrative order.

100.17(1) *When order may be established.* The department may establish a child or medical support obligation against a responsible person through the administrative process. This does not preclude child support services from pursuing the establishment of an ongoing support obligation through other available legal proceedings. When gathering information to establish a support order, child support services may obtain a form prescribed by the department or a similar document from the child's caretaker.

100.17(2) *Support debt.* When public assistance is paid to or Medicaid is received by a child of the responsible person, or the dependent child's caretaker, a support debt is created and assigned to the department. When no public assistance is paid or Medicaid is received, the debt is owed to the individual caretaker.

100.17(3) *Notice to responsible person.* When the department establishes a support debt against a responsible person, a notice of child support debt will be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26. The notice will include all of the rights and responsibilities shown in Iowa Code section 252C.3. The notice will also inform the responsible person that these rights may be waived pursuant to Iowa Code section 252C.12, and the procedures for and effect of waiving these rights. The notice will include a statement that failure to respond within the time limits given and to provide information and verification of financial circumstances will result in the entry of a default judgment for support.

100.17(4) *Negotiation conference.* The responsible person may, within ten calendar days after being served the notice of child support debt, request a negotiation conference with the office of child support services that sent the notice.

100.17(5) *Amount of support obligation.* Child support services will determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.

a. Any deviation from the guidelines will require a written finding by the department.

b. Reserved.

100.17(6) *Court hearing.* Either the responsible person or child support services may request a court hearing regarding the establishment of a support obligation through the administrative process.

a. The request for a hearing by the responsible person must be in writing and sent to the office of child support services that sent the original notice of the support debt by the latest of the following:

(1) Thirty days from the date of service of the first notice of support debt.

(2) Ten days from the date of the negotiation conference.

(3) Thirty days from the date the second notice and finding of financial responsibility is issued.

(4) Ten days from the date of issuance of the conference report if the department does not issue a second notice and finding of financial responsibility after a conference was requested.

b. When a request for a court hearing is received from the responsible person, within the time limits allowed, or is made by child support services, the department will schedule or request that the hearing be scheduled in the district court in the county:

(1) Where the dependent child resides if the child resides in Iowa.

(2) Where the responsible person resides if the child for whom support is sought resides in another state or the sole purpose of the administrative order is to secure a judgment for the time period that public assistance was expended by the state on behalf of the family or child.

100.17(7) *Exception to time limit.* The department may accept and respond to written requests for a court hearing beyond the time limits allowed in this rule.

100.17(8) *Entry of order.* If no request for a hearing is received from the responsible person at the local office of child support services, or made by child support services, the department may prepare an order for support and have it presented ex parte to the court for approval.

a. The attorney for child support services will present the order and other documents supporting the entry of the ex parte order to the court for review and approval. Pursuant to Iowa Code chapter 252C, the court will approve the order unless defects appear in the order or supporting documents.

b. The department will file a copy of the approved order with the clerk of the district court.

c. The department will send a copy of the filed order by regular mail, to the caretaker's last-known address, to the responsible person's last-known address or the caretaker's or the responsible person's attorney pursuant to the provisions of Iowa Code chapter 252C within 14 days after approval and issuance of the order by the court.

100.17(9) *Force and effect.* Once the order has been signed by the judge and filed, it will have all the force and effect of an order or decree entered by the court. Unless otherwise specified, the effective date of the support obligation will be the twentieth day following the date the order is prepared by child support services.

100.17(10) *Modification by department.* The department may petition an appropriate court for modification of a court order on the same grounds as a party to the court order can petition the court for modification.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25]

441—100.18(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[**ARC 8966C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 252C and 252F and sections 252A.6A, 598.21, and 600B.41A.

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CHAPTER 101
ADJUSTMENT AND MODIFICATION OF SUPPORT

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—101.1(252B,252H) Definitions.

"Additional child" means a child to be added to an existing support order covering another child of the same parents.

"Born of a marriage" means a child was born of a woman who was married at the time of conception, birth, or at any time during the period between conception and birth of the child pursuant to Iowa Code chapter 252A and section 144.13.

"Cost-of-living alteration" means the same as defined in Iowa Code section 252H.2.

"Guidelines" means the most current guidelines and criteria prescribed by the Iowa Supreme Court for determining the amount of child support to be awarded.

"Parent" means a person who is a responsible person or a caretaker, as those terms are defined in rule 441—95.1(252B).

"Recipient of service" means a person receiving foster care services, or a recipient of family investment program assistance or Medicaid benefits whose child support or medical support is assigned, or a person who is not receiving public assistance but who is entitled to child support enforcement services pursuant to Iowa Code section 252B.4.

"Substantial change of circumstances," means:

1. There has been a change of 50 percent or more in the net income of a parent, as determined by comparing the new net income with the net income upon which the current child support obligation was based, and
2. The change is due to financial circumstances that have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months, pursuant to Iowa Code section 252H.18A.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.2(252H) Confidentiality of financial information. Financial information provided to child support services by either parent for the purpose of facilitating the modification or review and adjustment processes may be disclosed to the other parties to the case, or the district court, as follows:

101.2(1) *Financial statements.* The financial statement or affidavit may be disclosed to either party.

101.2(2) *Other documentation.* Supporting financial documentation such as state and federal income tax returns, paycheck stubs, IRS Form W-2, bank statements, and other written evidence of financial status may be disclosed to the court unless otherwise prohibited by state or federal law.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.3(252H) Payment of fees.

101.3(1) Payment of service of process and other costs associated with the modification or review and adjustment processes is the responsibility of the party requesting the action unless the court orders otherwise or the requesting party, as a condition of eligibility for receiving public assistance benefits, has assigned the rights to child or medical support for the order to be modified.

101.3(2) A requesting party who is indigent or receiving public assistance may request deferral of fees and costs. For the purposes of this chapter, "indigent" means that the requesting party's income is 200 percent or less than the poverty level for one person as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981 as amended to August 1, 2024.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.4(252B,252H) Review of permanent child support obligations. Permanent child support obligations that are ongoing and being enforced by child support services or the child support agency of another state will be reviewed by child support services to determine whether or not to adjust the

obligation. Child support services will determine the appropriate obligation amount using the child support guidelines. Iowa must have continuing, exclusive jurisdiction to modify the order under Iowa Code chapter 252K.

101.4(1) *Periodic review.* A permanent child support obligation being enforced by child support services and meeting the conditions in Iowa Code section 252H.12 may be reviewed upon the initiative of child support services if:

a. The right to any ongoing child support obligation is currently assigned to the state due to the receipt of public assistance.

b. The support order does not already contain medical support provisions.

c. A review is otherwise necessary to comply with state or federal law.

101.4(2) *Review by request.* A review will be conducted upon the request of the child support agency of another state or upon the written request of either parent subject to the order submitted on a form prescribed by the department. One review may be conducted every two years when the review is being conducted at the request of either parent. The request for review may be no earlier than two years from the filing date of the support order or most recent modification or the last completed review, whichever is later.

101.4(3) *Review outcome.*

a. Procedures to adjust the support obligation will be initiated only when the financial and other information available to child support services indicates that the:

(1) Present child support obligation varies from the Iowa Supreme Court mandatory child support guidelines by more than 20 percent, and

(2) Variation is due to a change in financial circumstances that has lasted at least three months and can reasonably be expected to last for an additional three months.

b. Procedures to modify a support order may be initiated when the order does not include provisions for medical support.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.5(252B,252H) Notice requirements—review and adjustment. Child support services will provide written notification to each parent affected by a permanent child support obligation being enforced by child support services as follows:

101.5(1) *Notice of right to request review.* Child support services will notify each parent of the right to request review of the order and the appropriate place and manner in which the request should be made. Notification will be provided on forms prescribed by the department or through another printed or electronic format.

101.5(2) *Notice of review.* One of the following will apply:

a. At least 15 days before the review is conducted, child support services will serve notice of its intent to review the order on each parent affected by the child support obligation. This notice will include a request that the parties complete a financial statement and provide verification of income. The notice will be served in accordance with Iowa Code section 252B.26 or 252H.15.

b. If the conditions of Iowa Code section 252H.14A(1) are met, child support services may conduct a review using information accessible to child support services without:

(1) Issuing a notice under paragraph 101.5(2)*"a,"* or

(2) Requesting additional information from the parent.

101.5(3) *Notice of decision.* After child support services completes the review of the child support obligation in accordance with rule 441—101.4(252B,252H), child support services will issue a notice of decision in accordance with Iowa Code section 252H.14A or 252H.16 stating whether or not an adjustment is appropriate and, if so, child support services' intent to enter an administrative order for adjustment.

101.5(4) *Challenges to outcome of review.* Each parent will be allowed to request a second review challenging the determination of child support services. The procedure for challenging the determination is as follows:

a. The parent challenging the determination must submit the request for a second review in writing to child support services stating the reasons for the request and providing written evidence necessary to support the challenge. The request must be submitted:

(1) Within 10 days from the date of a notice of decision issued pursuant to Iowa Code section 252H.16, or

(2) Within 30 days from service of a notice of decision issued pursuant to Iowa Code section 252H.14A.

b. Child support services will review the written evidence submitted with the request and all financial information available to child support services and make a determination of one of the following:

(1) To enter an administrative order for adjustment of the obligation.

(2) That adjustment of the child support obligation is inappropriate.

c. Child support services will send written notice of the outcome of the second review to each parent affected by the child support obligation at the parent's last-known mailing address.

d. For a review initiated under Iowa Code section 252H.15, if either parent disputes the second decision, the objecting parent may request a court hearing within 15 days from the date the notice of decision is issued or within 10 days of the date the second notice of decision is issued, whichever is later.

e. For a review initiated under Iowa Code section 252H.14A, either parent may request a court hearing within 10 days of the issuance of the second notice of decision.

f. If child support services receives a timely written request or child support services determines that a court hearing is necessary, child support services will certify the matter to the district court. An objecting parent may seek recourse by filing a private petition for modification through the district court.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.6(252B,252H) Financial information—review and adjustment. Child support services will attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be reviewed necessary to conduct the review.

101.6(1) *Financial statements.* Except for a review initiated under Iowa Code section 252H.14A, both parents subject to the order to be reviewed must provide a financial statement and verification of income within ten days of service of the notice of child support services' intent to review the obligation. If a review is initiated under Iowa Code section 252H.14A and the first notice of decision is challenged as described in subrule 101.5(4), both parents will be requested to provide a financial statement and verification of income within ten days of child support services' request.

a. Verification of income will include but not be limited to the following: copies of state and federal income tax returns, W-2 statements, pay stubs, or a signed statement from an employer or other source of income.

b. Child support services may also request that the parent requesting review provide an affidavit regarding the financial circumstances of the nonrequesting parent when child support services is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent must complete the affidavit if the parent possesses sufficient information to do so.

101.6(2) *Independent sources.* Child support services may utilize other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be reviewed.

a. These resources include but are not limited to the following: the Iowa workforce development department, the Iowa department of revenue, the Internal Revenue Service, the employment, revenue, and child support recovery agencies of other states, and the Social Security Administration.

b. In the absence of other verification of income and deductions allowed under the mandatory support guidelines, child support services may estimate the net earned income of a parent for the purpose of determining the amount of support that would be due under the guidelines by deducting 20 percent from the gross earned income confirmed by an independent source. A parent may challenge this estimate by providing verification of actual earned income deductions.

101.6(3) *Availability of medical insurance.* Both parents subject to the order to be reviewed must provide documentation regarding the availability of health insurance coverage for the children covered under the order, and the cost of the coverage, within ten days of a written request by child support services. Verification may include but not be limited to: a copy of the health benefit plan including the effective date of the plan, a letter from the employer detailing the availability of health insurance, or any other source that will serve to verify health insurance information and the cost of the coverage.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.7(252B,252H) Review and adjustment of a child support obligation.

101.7(1) *Conducting the review.* Child support services will review the case for administrative adjustment of a child support obligation unless it is determined that any of the following exist:

a. The location of one or both of the parents is unknown.

b. The variation from the Iowa Supreme Court mandatory child support guidelines is based on any material misrepresentation of fact concerning any financial information submitted to child support services.

c. The criteria of rule 441—101.4(252B,252H) are not met.

d. The end date of the order is less than 12 months in the future or the youngest child is 17½ years of age.

101.7(2) *Civil action.* The review and adjustment action that is certified to court for hearing will proceed as an ordinary civil action in equity, and child support services attorney will represent the state of Iowa in those proceedings.

101.7(3) *Private counsel.* After the notice has been issued as described in subrule 101.5(2) or 101.5(3), any party may choose to be represented personally by private counsel. Any party who retains private counsel must notify child support services of this fact in writing.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—101.8(252B,252H) Medical support—review and adjustment. Child support services will review the medical support provisions contained in any permanent child support order that is subject to review under rule 441—101.7(252B,252H) and will include in any adjustment order a provision for medical support as defined in Iowa Code chapter 252E, and as set forth in 441—Chapter 98, or other appropriate provisions pertaining to medical support for all children affected directly by the child support order under review.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—101.9(252B,252H) Denying requests—review and adjustment. A request for review by a parent subject to the order may be denied for the following reasons:

101.9(1) It has been less than two years since the support order was filed with the court, last modified, or last reviewed for the purpose of adjustment.

101.9(2) Child support services or a child support agency of another state is not providing enforcement services for an ongoing support obligation under the order for which the review has been requested.

101.9(3) The request is based entirely on issues such as custody, visitation, or parenting time rights, which are not directly related to child support.

101.9(4) The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

101.9(5) The request is for the review of a temporary support order.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.10(252B,252H) Withdrawing requests — review and adjustment. If the requesting party contacts child support services to withdraw the request, child support services will proceed as follows:

101.10(1) *Consent of both parties.* Child support services will notify the nonrequesting party of the requesting party's desire to withdraw the request.

a. If the nonrequesting party indicates a desire to continue the review, child support services will proceed with the review and adjust the obligation, if appropriate.

b. If the nonrequestor indicates a desire to stop the process or fails to respond within ten days to the notification of the request to withdraw, child support services will notify all parties that the review and adjustment process has been terminated.

101.10(2) *Effect of withdrawal.* If a request is successfully withdrawn pursuant to subrule 101.10(1), a later request by either party will be subject to the limitations of subrule 101.4(2).

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.11(252H) Effective date of review and adjustment. Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation amount will be effective on the first date that

the periodic payment is due under the order being modified after child support services files the adjustment order with the court.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.12(252H) Availability of service—administrative modification. Child support services will provide administrative modification services for a support order originally entered or a foreign order registered in the state of Iowa. The order must be one that:

101.12(1) Involves at least one child born of a marriage or one child for whom paternity has been legally established.

101.12(2) Is being enforced by child support services in accordance with Iowa Code chapter 252B.

101.12(3) Is subject to the jurisdiction of this state for the purposes of modification.

101.12(4) Is not subject to or is not appropriate for review and adjustment.

101.12(5) Provides for support of at least one child under the age of 18 or a child between the ages of 18 and 19 years who is engaged full-time in completing high school graduation or equivalency requirements in a manner that is reasonably expected to result in completion of the requirements prior to the person's reaching 19 years of age.

101.12(6) Has an obligation ending more than 12 months in the future.

101.12(7) Involves parents for whom the location of both parents is known.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.13(252H) Modification of child support obligations. Permanent child support obligations meeting the criteria set forth in rule 441—101.12(252H) may be modified at the initiative of child support services, or upon written request of either parent subject to the order submitted on a form prescribed by the department. Any action will be limited to adjustment, modification, or alteration of the child support or medical provisions of the support order. The duration of the underlying order will not be modified. The procedures used by child support services to determine if a modification is appropriate are as follows:

101.13(1) *Substantial change of circumstances.* Procedures to modify the support obligation may be initiated outside the minimum time frame described in subrule 101.4(2) if a request is received from either parent and if the parent has submitted verified documentation of a substantial change in circumstances that indicates both of the following:

a. A change of at least 50 percent in the net income of a parent as defined by guidelines. The new net income will be compared to the net income upon which the current child support obligation was based.

b. The change is due to financial circumstances that have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months.

Child support services will review the request and documentation and, if appropriate, issue a notice of intent to modify as described in subrule 101.14(1).

101.13(2) *Adding provisions for additional children.* Procedures to modify the support obligation may be initiated if:

a. A parent requests, in writing, or child support services determines that it is appropriate to add an additional child to the support order and modify the obligation amount according to the guidelines pursuant to Iowa Code sections 598.21B and 252B.7A; and

b. Paternity has been legally established.

When adding a child to an order through administrative modification, medical support provisions will apply to the additional child.

101.13(3) *Reserved, zero-dollar-amount, or medical-provisions-only orders.* Procedures to modify the support obligation may be initiated if:

a. A parent requests a modification in writing or child support services determines that it is appropriate to include a support amount based on the guidelines; and

b. The original order:

(1) Reserved establishment of an ongoing, dollar-amount support obligation giving a specific reason other than lack of personal jurisdiction over the obligor, or

(2) Set the amount at zero, or

(3) Was for medical provisions only.

101.13(4) *Corrections.* Procedures to modify the support obligation may be initiated if:

a. An error or omission pertaining to child support or medical provisions was made during preparation or filing of a support order; and

b. A necessary party requests a modification or child support services determines that a modification to correct an error or omission is appropriate.

101.13(5) *Noncompliance by minor obligors.* The unit may initiate procedures to modify a support order if a parent requests modification in writing or the unit determines that it is appropriate when:

a. An obligor who is under 18 years of age fails to comply with the requirement to attend parenting classes pursuant to Iowa Code section 598.21G; or

b. An obligor who is 19 years of age or younger fails to provide proof of compliance with education requirements described in Iowa Code section 598.21B(2)*"e"*; or

c. The obligor no longer meets the age requirements as defined in Iowa Code section 598.21B(2)*"e"* or 598.21G.

101.13(6) *Cost-of-living alteration.* A support order may be modified to provide a cost-of-living alteration if all the following criteria are met:

a. Those criteria established in Iowa Code section 252H.23.

b. At least two years have passed since the order was filed with the court or last reviewed, modified, or altered.

c. The current support order addresses medical support for the children.

d. A copy of each affected order is provided, if child support services does not already have copies in its files.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.14(252H) Notice requirements—administrative modification. Child support services will provide written notification to parents affected by a permanent child support obligation being enforced by child support services as follows:

101.14(1) *Notice of intent to modify.* When a request for administrative modification is received or child support services initiates an administrative modification, child support services will provide written notice to each parent of its intent to modify.

a. The notice will include the legal basis and purpose for the action; a request for income or other information necessary for the application of guidelines (if applicable); an explanation of the legal rights and responsibilities of the affected parties, including time frames; and procedures for contesting the action.

b. Child support services will take the following actions to notify parents:

(1) If the modification is based on subrules 101.13(1) through 101.13(5), notice will be provided to each parent. The notice will be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26 or 252H.19.

(2) If the modification is based on provision of a cost-of-living alteration as established at subrule 101.13(6) and the required documentation is included, child support services will notify each parent of the amount of the cost-of-living alteration by regular mail to the last-known address of each parent or, if applicable, each parent's attorney. The notice will include:

1. The method of determining the amount of the alteration pursuant to Iowa Code section 252H.21.

2. The procedure for contesting a cost-of-living alteration by making a request for review of a support order as provided in Iowa Code section 252H.24.

3. A statement that either parent may waive the 30-day notice waiting period. If both parents waive the notice waiting period, child support services may prepare an administrative order altering the support obligation.

101.14(2) *Notice of decision to modify.* Child support services will issue a notice of its decision to modify the support order to each parent affected by the support obligation at each parent's (or attorney's) last-known address. The notice will contain information about whether child support services will continue or terminate the action and the procedures and time frames for contesting the action by requesting a court hearing pursuant to subrule 101.16(2).

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.15(252H) Financial information—administrative modification. Child support services may attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be modified that is necessary to conduct an analysis and determine support. Child support services does not require financial information if the request is for a cost-of-living alteration.

101.15(1) *Financial statements.* Parents subject to the order must provide a financial statement and verification of income within ten days of a written request by child support services.

a. If the modification action is based on a substantial change of circumstances:

(1) The requesting party must provide a form prescribed by the department, and documentation that proves the amount of change in net income and the date the change took place, such as:

1. Copies of state and federal income tax returns, W-2 statements, or pay stubs, or
2. A signed statement from an employer or other source of income.

(2) Child support services will review the request and documentation. If appropriate, child support services will issue to each parent a notice of intent to modify the order as stated in subrule 101.14(1) and a financial statement. Each parent must complete and sign the financial statement and return it to child support services with verification of income and deductions as described in subrule 99.1(3).

b. Child support services may require a completed and signed financial statement and verification of income from each parent as described in subrule 99.1(3) if the modification is based on:

(1) Addition of a child;
(2) Changing a reserved or zero-dollar-amount obligation;
(3) Changing a medical-provisions-only obligation;
(4) Making a correction (if financial information is needed); or
(5) Noncompliance by a minor obligor as defined in Iowa Code section 598.21B(2)*"e"* or 598.21G.

c. Child support services may also request that a parent requesting a modification provide an affidavit regarding the financial circumstances of the nonrequesting parent when child support services is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent must complete the affidavit if the parent possesses sufficient information to do so.

d. Child support services may also use occupational wage rate information or the median income for parents on child support services' caseload to determine the gross income of a parent when a parent has failed to return a completed financial statement when requested and complete and accurate information is not readily available from other sources.

e. Self-employment income will be determined as described in subrule 99.1(5).

101.15(2) *Independent sources.* Child support services may use other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be modified as described in rule 441—99.1(234,252B,252H).

101.15(3) *Guidelines calculations.* Child support services will determine:

a. The appropriate amount of the child support obligation (excluding cost-of-living alteration amounts) as described in rules 441—99.1(234,252B,252H) through 441—99.5(234,252B), and

b. Medical support provisions as described in Iowa Code chapter 252E and rules 441—98.2(252E) through 441—98.5(252E) and 441—75.14(249A).

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.16(252H) Challenges to the proposed modification action. For modification actions based on subrules 101.13(1) through 101.13(5), each parent will have the right to request a conference to contest the proposed modification. Either parent, or child support services, may also request a court hearing. For requests made based on subrule 101.13(6), either parent may contest the cost-of-living alteration by making a request for a review and adjustment of the support order.

101.16(1) *Conference.* Either parent may contest the proposed modification based on subrules 101.13(1) through 101.13(5) by means of a conference with the office of child support services that issued the notice of intent to modify.

a. Only one conference will be held per parent.

b. The request must be made within ten days of the date of service of the notice of intent to modify.

c. The office that issued the notice of intent to modify will schedule a conference with the parent and advise the parent of the date, time, place, and procedural aspects of the conference.

d. Reasons for contesting the modification include but are not limited to mistake of fact regarding the identity of one of the parties or the amount or terms of the modification.

e. Child support services may conduct the conference in person or by telephone.

f. If the party who requested the conference fails to attend the conference, only one alternative time will be scheduled by child support services.

g. The results of a conference will in no way affect the right of either party to request a court hearing pursuant to subrule 101.16(2).

h. Upon completion of the conference, child support services will issue a notice of decision to modify as described in subrule 101.14(2).

101.16(2) *Court hearing.*

a. Either parent, or child support services, may contest the proposed modification, based on subrules 101.13(1) through 101.13(5), by requesting a court hearing within the latest of any of the following time periods:

(1) Twenty days from the date of successful service of the notice of intent to modify,

(2) Ten days from the date scheduled for a conference, or

(3) Ten days from the date of issuance of a notice of decision to modify.

b. If child support services receives a timely written request, child support services will certify the matter to the district court as described in Iowa Code section 252H.8.

c. If a timely request is not received, if waiting periods have been waived, or if the notice periods have expired, child support services will prepare an administrative order as provided in Iowa Code section 252H.9.

101.16(3) *Contesting a proposed cost-of-living alteration.* Either parent may contest a cost-of-living alteration within 30 days of the date of the notice of intent to modify by making a request for a review of the support order as provided in Iowa Code section 252H.13.

a. If child support services receives a timely written request for review, child support services will terminate the cost-of-living alteration process and proceed with the review and adjustment process.

b. If a timely request is not made, or the notice waiting period has been waived by both parties, or the notice period has expired, child support services will prepare an administrative order as provided in Iowa Code section 252H.24.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.17(252H) Misrepresentation of fact—administrative modification.

101.17(1) Child support services will not modify the support order based on a substantial change of circumstances if a change in income is due to any material misrepresentation of fact concerning any financial information submitted to child support services.

101.17(2) Child support services may request verification that all facts concerning financial information are true. Verification may include but is not limited to a statement from the employer, a doctor, or other person with knowledge of the situation.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.18(252H) Effective date of modification. Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation will be effective on the first date that the periodic payment is due under the order being modified after child support services files the modification order with the court. If the modification is based on a reserved, zero-dollar-amount, or medical-provisions-only obligation, the new obligation will be effective 20 days after generation of the administrative modification order.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.19(252H) Denying requests—administrative modification. A request for modification by a parent subject to the order may be denied if the criteria in rule 441—101.12(252H) are not met or the following conditions exist:

101.19(1) *Nonsupport issues.* The request is based entirely on issues such as custody, visitation, or parenting time rights.

101.19(2) *Request only for delinquent support.* The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

101.19(3) *Temporary order.* The request is for the modification of a temporary support order.

101.19(4) *Two-year time frame.* The request is for a cost-of-living alteration and it has been less than two years since the order was filed with the court or last reviewed, modified, or altered.

101.19(5) *Change of circumstances.* The request is based on a substantial change in circumstances and:

a. The requestor's net income has not changed by at least 50 percent, as required in paragraph 101.13(1)*"a,"* or

b. The requestor has not provided adequate documentation of the change in income, as required in subrule 101.15(1), or

c. The change in income has not yet lasted for three months, as required in paragraph 101.13(1)*"b,"* or

d. The change in income is not expected to last another three months, as required in paragraph 101.13(1)*"b,"* or

e. The change in income is due to material misrepresentation of fact, as explained in rule 441—101.17(252H).

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.20(252H) Withdrawing requests—administrative modification. If the requesting party contacts child support services to withdraw the request, child support services will notify the nonrequesting party of the requesting party's desire to withdraw the modification request. If the nonrequesting party indicates, in writing, a desire to continue with the modification process, child support services will proceed, and if appropriate, modify the support order. If there is no response from the nonrequesting party or if the nonrequesting party also wants the process to end, child support services will end the modification process. If child support services initiated the modification action, child support services may terminate the process if, after notifying both parents, neither parent indicates a desire to continue with the modification.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25]

441—101.21(252B,252H) Child care add-on. Child support services will review a child care add-on or expense agreement contained in any permanent child support order that is subject to review under rule 441—101.7(252B,252H) or 441—101.13(252H) as follows:

101.21(1) *Order with child care add-on.*

a. If the custodial parent provides the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)*"c,"* child support services will review the information and apply the child care add-on based on the guidelines, if appropriate. Any resulting child care add-on will replace the existing child care add-on.

b. If the custodial parent does not provide the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)*"c,"* the resulting modified child support amount will no longer include an added amount for child care expenses.

101.21(2) *Order with child care expense agreement.* Child support services will review an order with an existing child care expense agreement entered in lieu of a child care add-on as follows:

a. If the custodial parent provides the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)*"c,"* child support services will review the information and apply the child care add-on based on the guidelines, if appropriate. Any resulting child care add-on will replace the existing child care expense agreement.

b. If the custodial parent does not provide the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)*"c,"* child support services will recommend that any existing child care expense agreement remain unchanged.

101.21(3) *Order without a child care add-on or expense agreement.* If the custodial parent provides the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)*"c"* and there is no current child care expense agreement or child care add-on,

child support services will review the information and apply the appropriate child care add-on based on the guidelines.

[**ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—101.22(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[**ARC 8967C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 252H and sections 252B.5, 252B.7, and 598.21C(2).

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

CHAPTER 102
SUSPENSION AND REINSTATEMENT OF SUPPORT

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—102.1(252B) Definitions.

"Caretaker" means a natural person with whom a child is residing and who is not legally entitled to receive support for that child pursuant to the order that is the subject of the pending suspension request.

"Child" means the same as defined in Iowa Code section 252E.1.

"Obligee" means a custodial parent or other natural person legally entitled to receive a support payment on behalf of a child.

"Obligor" means a noncustodial parent or other natural person who is ordered to pay support pursuant to the order that is the subject of the pending suspension request.

"Public assistance" means the same as defined in Iowa Code section 252H.2.

"Spousal support" means either a set amount of monetary support, or medical support as defined in Iowa Code section 252E.1, for the benefit of a spouse or former spouse, including alimony, maintenance, or any other term used to describe these obligations.

"Step change" means a change designated in a support order that specifies the amount of the child support obligation as the number of children entitled to support under the order changes.

"Support" means the same as defined in Iowa Code section 252D.16 and will include support for a child.

"Support for a child" means either a set amount of monetary support (child support and any applicable child care add-on), or medical support as defined in Iowa Code section 252E.1, for the benefit of a child. This term does not include spousal support as defined in this rule.

"Support order" means the same as a "court order" as defined in Iowa Code section 252C.1.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—102.2(252B) Availability of service—suspension by mutual consent. Child support services will provide suspension by mutual consent only with respect to support orders entered or registered in this state for which child support services is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

102.2(1) Suspension by mutual consent will only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order under Iowa Code chapter 252K.

102.2(2) Suspension by mutual consent will be provided only if no prior request for suspension of all or part of a support order has been filed with child support services pursuant to Iowa Code section 252B.20 and no prior request for suspension of all or part of a support order has been served by child support services pursuant to Iowa Code section 252B.20A during the two-year period preceding the request.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.3(252B) Basis for suspension of support by mutual consent.

102.3(1) *Reconciliation.* Child support services will assist an obligor and obligee in suspending support for a child and, if contained in a child support order, spousal support, when the obligor and obligee are reconciled and are residing together, with at least one child entitled to support under the order, in the same household.

102.3(2) *Change in residency.* Child support services will assist an obligor and obligee in suspending support for a child when the child is residing with the obligor; however, child support services will not assist in suspending any spousal support provisions of a support order on this basis. Child support services will also assist an obligor and obligee in suspending support for a child residing with a caretaker who has not requested services, if the child is not receiving public assistance.

102.3(3) *Affected children.* Child support services will assist an obligor and obligee in suspending by mutual consent all or part of a support order if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

a. If the basis for suspension applies to all of the children, child support services will assist in suspending support obligations for all of the children.

b. If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, child support services will assist in suspending the support obligations for children for whom the basis for suspension applies.

c. If the basis for suspension applies to at least one but not all of the children and if the support order includes a child care add-on, child support services will assist in suspending the child care add-on if child support is being suspended for all of the children who are then subject to the child care add-on. If child support is not being suspended for all of the children who are then subject to the child care add-on and the support order does not apportion the child care add-on between those children, child support services will not assist in suspending the child care add-on. If the support order does not state whether a specific child care add-on amount is included in the step change amounts, child support services will assist in suspending support as set forth in paragraph 102.3(3)*"b."*

102.3(4) *Limited to current support.* The provisions for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.

102.3(5) *Duration of conditions.* The basis for suspension of support as provided in subrule 102.3(2) and subrule 102.3(3) must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by child support services.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—102.4(252B) Request for assistance to suspend by mutual consent.

102.4(1) *Submitting a request.* The obligor and obligee subject to a support order being enforced by child support services may request that child support services assist in having the ongoing support provisions suspended as follows:

a. A request for suspension must be submitted to child support services using a request and affidavit form prescribed by the department.

b. Child support services will provide the request and affidavit form prescribed by the department to the obligor and obligee upon request.

c. Both forms must be signed by both the obligor and the obligee affected by the order to be suspended. In the event that current support payments are assigned to an individual or entity other than the obligee named in the original order, but may revert to the original obligee at a future date without court action, both the original obligee and the current assignee must sign both forms.

d. The affidavit form prescribed by the department must be notarized.

e. The request must contain sufficient information to allow child support services to identify the court order and parties involved, and a statement that the obligor and obligee expect the basis for suspension to continue for not less than six months.

f. If the obligor and obligee are requesting suspension of more than one order at the same time, the obligor and obligee will be required to submit only one copy of the request form prescribed by the department, identifying each order the request involves; however, the obligor and obligee will be required to submit a separate, signed and notarized affidavit form prescribed by the department for each order.

102.4(2) *Denying a request.* Child support services will issue a written notice to the obligor and obligee indicating that a properly completed request is denied.

a. This notice will be sent by first-class regular mail to the last-known address of the obligor and obligee or, if applicable, to the last-known address of the obligor's or obligee's attorney.

b. If the basis for suspension is reconciliation, one notice will be sent to the address shared by the obligor and obligee. If the basis for suspension is a change in residency of the children entitled to support, a separate notice will be issued to the obligor and obligee at their respective last-known addresses.

c. The notice denying a request will indicate the reason for denial.

d. A request for suspension will be denied when the conditions specified in Iowa Code section 252B.20 or rule 441—102.2(252B) or 441—102.3(252B) are not met.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.5(252B) Order suspending support by mutual consent. To approve a request to suspend support, child support services will prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20.

102.5(1) When the basis for suspension is reconciliation, the suspension will apply to any ongoing support provisions of the order, including medical support, with respect to any child residing with the parents and with respect to any spouse or former spouse entitled to support under the order to be suspended.

102.5(2) When the basis for suspension is a change in residency of one or more of the children entitled to support, the suspension will apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor. Any spousal support also ordered in the same support order will remain unaffected by this action.

102.5(3) A copy of the filed order will be sent by first-class regular mail to the last known address of the obligor and obligee, or, if applicable, to the last known address of the obligor's or obligee's attorney.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.6(252B) Suspension of enforcement of current support—suspension by mutual consent. Child support services will suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. Child support services will continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.7(252B) Availability of service—suspension by payor's request. Child support services will provide suspension by payor's request only with respect to support orders entered pursuant to Iowa Code chapter 252A, 252C or 252F for which child support services is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

102.7(1) Suspension by payor's request will only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order pursuant to Iowa Code chapter 252K.

102.7(2) Suspension by payor's request will be provided only if no prior request for suspension of all or part of a support order has been filed with child support services pursuant to Iowa Code section 252B.20 and no prior request for suspension of all or part of a support order has been served by child support services pursuant to Iowa Code section 252B.20A during the two-year period preceding the request.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.8(252B) Basis for suspension of support by payor's request.

102.8(1) *Child residing with obligor or caretaker.* Child support services will assist an obligor in suspending support for a child residing with the obligor or with a caretaker who has not requested unit services, if the child has been residing with the obligor or caretaker for more than 60 consecutive days.

102.8(2) *Orders eligible for suspension.*

a. Child support services will assist an obligor in suspending support for a child only when there is no order in effect regarding legal custody, physical care, visitation, or parenting time for the child.

b. If an order exists that contains language regarding legal custody, physical care, visitation, or parenting time for the child, child support services will deny the suspension request.

102.8(3) *Children on public assistance.* The children for whom ongoing support is being suspended must not be receiving public assistance pursuant to Iowa Code chapter 239B or 249A or a comparable law of another state or foreign country, or if the children are receiving public assistance, the obligor must be considered to be a member of the same household as the children for the purposes of public assistance eligibility.

102.8(4) *Duration of conditions.* The basis for suspension of support must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by child support services.

102.8(5) *Affected children.* Child support services will assist an obligor in suspending by payor's request all or part of a support order if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

a. If the basis for suspension applies to all of the children, child support services will assist in suspending support obligations for all of the children.

b. If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, child support services will assist in suspending the support obligations for children for whom the basis for suspension applies.

c. If the basis for suspension applies to at least one but not all of the children and if the support order includes a child care add-on, child support services will assist in suspending the child care add-on if child support is being suspended for all of the children who are then subject to the child care add-on. If child support is not being suspended for all of the children who are then subject to the child care add-on and the support order does not apportion the child care add-on between those children, child support services will not assist in suspending the child care add-on. If the support order does not state whether a specific child care add-on amount is included in the step change amounts, child support services will assist in suspending support as set forth in paragraph 102.8(5)*"b."*

102.8(6) *Limited to current support.* The provisions for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—102.9(252B) Request for assistance to suspend by payor's request. The obligor subject to a support order being enforced by child support services may request that child support services assist in having the ongoing support provisions suspended as follows:

102.9(1) *Submitting a request.*

a. A request for suspension must be submitted to child support services using a form prescribed by the department.

b. Child support services will provide the request form prescribed by the department to the obligor upon request.

c. The request form must be signed by the obligor affected by the order to be suspended.

d. The request must contain sufficient information to allow child support services to identify the court order and parties involved and must attest that the children have lived in the obligor's household or the caretaker's household for more than 60 consecutive days and are expected to live there for at least six months.

102.9(2) *Submitting an affidavit.* After receiving a valid request for suspension, child support services will provide the requestor with an affidavit form prescribed by the department.

a. The obligor must submit the affidavit for suspension to child support services. If the request for suspension is made pursuant to Iowa Code section 252B.20A(17), the caretaker must also submit an affidavit form prescribed by the department.

b. The affidavit prescribed by the department must be signed, attesting to the existence of the conditions under subrules 102.8(1) through 102.8(4). The affidavit must be notarized.

c. If the obligor is requesting suspension of more than one order at the same time, the obligor will be required to submit only one copy of the request form prescribed by the department, identifying each order the request involves; however, the obligor will be required to submit a separate, signed and notarized affidavit form prescribed by the department for each order.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.10(252B) Determining eligibility for suspension by payor's request. Upon receipt of the request for suspension and the properly executed and notarized affidavit, child support services will review the request and the affidavit to determine that the criteria have been met.

102.10(1) *If the criteria are not met.* If the criteria have not been met, child support services will issue a written notice to the obligor indicating that the request is denied.

a. The notice will be sent by first-class regular mail to the last-known address of the obligor or, if applicable, to the last-known address of the obligor's attorney.

b. The notice will indicate the reason for denial and notify the obligor of the right to proceed through private counsel.

102.10(2) *If the criteria are met.* If the criteria are met, child support services will proceed as follows:

a. Child support services will serve forms prescribed by the department and supporting documents on the obligee by any means provided in Iowa Code section 252B.26. The notice to the obligee will include all of the following:

(1) Information sufficient to identify the parties and the support order affected.

(2) An explanation of the procedure for suspension and reinstatement of support in this chapter.

(3) An explanation of the rights and responsibilities of the obligee to respond to the action.

(4) A statement that, within 20 days of service, the obligee must submit a signed and notarized response to child support services objecting to at least one of the assertions in subrules 102.8(1) through 102.8(4). The statement will inform the obligee that if, within 20 days of service, the obligee fails to submit a response as specified in this subparagraph, notwithstanding Rules of Civil Procedure 1.972(2) and 1.972(3), child support services will prepare and submit an order.

b. No sooner than 30 days after service on the obligee, child support services will do one of the following:

(1) If the obligee submits a signed and notarized objection to at least one of the assertions in subrules 102.8(1) through 102.8(4), deny the request and notify the parties in writing that the request is denied, providing reasons for the denial, and notifying the parties of the right to proceed through private counsel.

(2) If the obligee cannot be served, child support services will issue a written notice to the obligor indicating the request is denied, following the procedure described in subrule 102.10(2).

(3) If the obligee does not timely submit a signed and notarized objection to child support services, prepare an order following the procedure described in rule 441—102.11(252B).

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.11(252B) Order suspending support by payor's request. After approving a request to suspend support and properly serving the obligee, child support services will prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20A.

102.11(1) The suspension will apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor or caretaker.

102.11(2) A copy of the filed order will be sent by first-class regular mail to the last-known address of the obligor and obligee or, if applicable, to the last-known address of the obligor's or obligee's attorney.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.12(252B) Suspension of enforcement of current support—suspension by payor's request. Child support services will suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. Child support services will continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.13(252B) Request for reinstatement. Child support services may request that the court reinstate the suspended support obligation in accordance with the procedures found in Iowa Code sections 252B.20 and 252B.20A.

102.13(1) Either the obligor or the obligee affected by the suspended order may request reinstatement by submitting a written request for reinstatement to child support services. The request must indicate that reinstatement is being requested and the reason for reinstatement and must contain sufficient information to identify the court order and parties involved. The request must also be signed by the requesting party.

102.13(2) Child support services may, at its own initiative, request that the court reinstate a support obligation when it is determined that a child for whom the obligation was suspended is receiving public assistance benefits.

102.13(3) Child support services will issue a written notice approving or denying the request to any obligor or obligee requesting reinstatement. This notice will be sent by first-class regular mail to the last-known address of the requesting party and will indicate any reason for denial.

102.13(4) A properly completed request for reinstatement will be denied when any of the following conditions exist:

a. The request is made by someone other than the obligor, the obligee, or the obligor's or obligee's attorney.

b. Child support services is no longer providing enforcement services for the suspended order.

c. The request is received more than six months after the date of the filing of the order suspending support.

d. The request is for partial reinstatement of the suspended support order for some but not all of the children, and the order does not contain a step change.

e. A court in this state would not have continuing, exclusive jurisdiction to reinstate the order under Iowa Code chapter 252K.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.14(252B) Reinstatement. Child support services will follow the procedures in Iowa Code sections 252B.20 and 252B.20A in seeking to have the court reinstate a support order.

102.14(1) Child support services will request that the court reinstate a spousal support provision previously suspended if the provision was included in the suspension in accordance with subrule 102.5(1) and if child support services receives a properly completed request from the obligor or the obligee.

102.14(2) Child support services will seek to have the previously suspended support for a child reinstated when the conditions in paragraph 102.14(2)*"a"* or *"b"* are met. This provision will not prohibit any party, including child support services, from taking other action to establish support as provided for by law.

a. The basis for suspension no longer applies to any of the children for whom support was suspended; or

b. The basis for suspension continues to apply to some but not all of the children for whom support was suspended, and there is a step change in the order.

102.14(3) Child support services will seek to have a previously suspended child care add-on reinstated when seeking to reinstate child support for one or more children who are subject to the child care add-on.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25; **ARC 9764C**, IAB 11/26/25, effective 1/1/26]

441—102.15(252B) Reinstatement of enforcement of support. If a suspended support obligation is reinstated, child support services will also reinstate all appropriate enforcement measures to enforce all reinstated ongoing support provisions of the support order.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.16(252B) Temporary suspension becomes final. The temporary suspension of a support order under this chapter will become final if not reinstated in accordance with Iowa Code sections 252B.20 and 252B.20A.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25]

441—102.17(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[**ARC 8968C**, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 252B.

[Filed ARC 8968C (Notice ARC 8558C, IAB 12/25/24), IAB 2/19/25, effective 4/1/25]

[Filed ARC 9764C (Notice ARC 9582C, IAB 10/1/25), IAB 11/26/25, effective 1/1/26]

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

CHILDREN'S INSTITUTIONS

TITLE XI

CHAPTER 103
STATE TRAINING SCHOOL

[Prior to 7/1/83, Social Services[770] Ch 103]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 12/1/31

441—103.1(218) Definitions.

"Child" means a person under the age of 18 years.

"Contraband" means weapons; ammunition; tobacco; alcohol; drugs; money; altered authorized property; mood-altering plant material; obscene material as defined in Iowa Code section 728.1(5); explosives; material that can be used in the manufacture of explosives; or material advocating disruption of or injury to students, employees, programs, or physical facilities. "Contraband" includes anything that is illegal to possess under federal or state law and materials that are used in the production of drugs or alcohol or used in conjunction with the taking of illicit drugs. "Contraband" also includes anything determined to be banned from individual possession by published facility rules.

"Division director" means the administrator of the division of state-operated specialty care within the department.

"Facility" means the state training school.

"Family" means spouse, child, parent, sibling, or grandparent.

"Gift or bequest" means anything of value that a facility receives that is intended for use directly by the employees of the facility. Items intended for public distribution, such as clothes or furniture, do not constitute a gift to the facility.

"Grievance" means a written or oral complaint by or on behalf of a student that involves:

1. A rights violation or unfairness to the student, or
2. Any aspect of the student's life with which the student does not agree.

"Iowa sex offender registry" means a central registry of sex offenders established under Iowa Code chapter 692A that is maintained by the department of public safety.

"Juvenile court officer" means the same as defined in Iowa Code section 232.2(35).

"Juvenile offender" means a juvenile who is required to be registered with the Iowa sex offender registry and with the sheriff of the juvenile's county of residence.

"Legal representative" means a person, including an attorney, who is authorized by law to act on behalf of a student.

"Money" means all forms of currency, checks, money orders, stocks, bonds, and any other item that can be used as a medium of exchange for payment for goods or services.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Registration" means the submission of registration forms to the Iowa sex offender registry and to the sheriff of the person's county of residence.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"State training school" means the same as defined in Iowa Code section 233A.1(3).

"Student," as used in this chapter, means any child who is committed to the director and is admitted to and receives services from the state training school. The terms "resident," "juvenile," and "youth" are synonymous with the term "student." For purposes of the state training school, the term also includes a person whose stay is extended beyond the age of 18 under the provisions of Iowa Code section 232.53(2) and 232.53(4).

"Superintendent" means the same as defined in Iowa Code section 233A.1(3).

"Tobacco" means all forms of tobacco.

"Weapon" means any gun, knife, tool, object, or chemical that can be used to inflict harm on oneself or another.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.2(218) Admission.

103.2(1) *Population guidelines.* The facility population level will be based on the population guidelines that the judicial branch, in consultation with the department, develops on the number of students who may be placed at a juvenile facility at any one time. Pursuant to those guidelines and the responsibility of the superintendent for admission of students, the superintendent and the chief juvenile court officers will allocate to each judicial district the number of children from each district who may be placed in the facility for diagnosis and evaluation and for treatment.

103.2(2) *Acceptance of child.* A certified copy of the court order that complies with Iowa Code chapter 232 shall accompany the child to the facility, along with the relevant petitions.

a. A child will be accepted for evaluation as specified in the court order only when a diagnostic bed is available.

b. A child will be accepted into the regular program as specified in the court order only when a treatment bed is available.

c. A child adjudicated as a child in need of assistance shall not be admitted to the state training school, except:

(1) For diagnosis and evaluation and then only when a current petition is on file that alleges the child to have committed a delinquent act, or

(2) When the child is also adjudicated delinquent and meets admission criteria for the state training school as a delinquent.

d. The superintendent or chief juvenile court officer shall notify the court when the appropriate space, service, or program is not available so that admission can be ordered when the facility can meet the child's needs.

103.2(3) *Time of admission.* When a child is to be admitted to the facility, arrangements will be agreed to by the facility for the date and time of the actual admission.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.3(218) Plan of care.

103.3(1) *Individual care plan conference.* The facility will schedule an individual care plan conference and provide prior notice to:

a. The student;

b. The student's parents or guardians;

c. The student's legal representative;

d. The student's juvenile court officer; and

e. The court.

103.3(2) *Prerelease conference.* A prerelease conference will be held 30 days before any anticipated release of a student from the regular program. The focus of the conference will be to help the student plan for a successful transition into the community by leveraging local community services. The facility will provide written notice of the time, date, and purpose of the conference to:

a. The student;

b. The student's parents or guardians;

c. The student's legal representative;

d. The student's juvenile court officer; and

e. The court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.4(218) Communication with students.

103.4(1) *Incoming telephone calls.* The superintendent or superintendent's designee must approve all incoming telephone calls for a student before the conversation occurs. An authorized employee will verify the identity of the caller before approval is given. Approved telephone calls will not be monitored.

103.4(2) *Mail and packages.*

a. The facility will maintain policies and procedures for outgoing or incoming letters and packages, including the facility's ability to search for and seize contraband by:

(1) Opening, but not reading, incoming and outgoing letters and packages in the presence of the student to whom the letters and packages belong; or

(2) Requiring that the student open the letters and packages in an employee's presence and disclose the contents.

b. Letters or packages found to contain contraband will be confiscated. Both the sender and the intended receiver of the confiscated letters and packages will be notified and given reasons for the action.

c. The superintendent or superintendent's designee may terminate correspondence between a student and another person when the student's treatment team has determined that the correspondence is not in the student's best interest and is detrimental to the student's treatment plan. Termination will be based on the circumstances of each case.

(1) The superintendent or superintendent's designee will provide justification to terminate the correspondence in a written notice to the correspondents.

(2) Correspondents may file a grievance concerning the termination.

103.4(3) *Visits.* The facility will maintain policies and procedures to allow for reasonable visitation. Visits by a student's family or legal representative will be encouraged. Flexibility in the hours and days of visitation will be considered as necessary.

a. Applicability. Other than a family member or legal representative, a person who wants to visit a student shall obtain prior approval from the student's juvenile court officer and the superintendent or superintendent's designee before visiting. Visitation rights will be denied to:

(1) A former facility resident unless the former resident is a family member or has prior approval of the superintendent or superintendent's designee;

(2) A parent whose parental rights have been terminated or limited by court order;

(3) A person who is restricted by court order from contact with the student;

(4) A visitor who refuses to cooperate with the rules of the facility;

(5) A visitor who creates a disturbance or is hostile to the point of being disruptive;

(6) A visitor who passes or attempts to pass contraband to a student or who aids in an escape or attempted escape;

(7) A visitor who is under the influence of or has been partaking of drugs or alcoholic beverages; and

(8) Any other person who, based on reasonable cause, is believed to pose a risk to the student's treatment or to the safety or security of the facility.

b. Limitations.

(1) A student shall not be permitted to visit with the family of another student unless the student's juvenile court officer and the superintendent or superintendent's designee have given prior approval. A student shall have written authorization of the student's juvenile court officer and the superintendent or superintendent's designee before accompanying the parents of another student off grounds on a visit.

(2) The superintendent reserves the right to limit or terminate visiting in all cases when doing so is in the best interests of the student's personal and therapeutic needs. When limitation or termination of visiting rights occurs, the superintendent or superintendent's designee will:

1. Immediately notify persons involved why the action was taken; and
2. Document the action in the student's file.

103.4(4) *Attorney contacts.* A student's attorney shall have the right to visit or have telephone contact with the student at any reasonable time.

a. A student shall have the right to contact the student's attorney during normal business hours and at other times with prior approval of the attorney. Responsibility for payment for the cost of the contact shall be determined before the contact is made.

b. A student who does not have an attorney will be referred to the committing court for an attorney to be appointed.

103.4(5) *Interviews and statements.*

a. Request. Requests to interview a student made by media (newspapers, television stations, radio stations, etc.), groups, or persons not related to the student shall be made through the superintendent's office.

(1) The superintendent or superintendent's designee will inform the student of the request and of the student's right to agree to participate in the interview or to remain silent and not participate.

(2) If an interview may have an impact on the student's legal status, the superintendent or superintendent's designee will contact the student's attorney to determine if the attorney has any objection to the student's participation.

b. Decision. When a student agrees to participate, the interview will be granted at the discretion of the superintendent. The superintendent may deny an interview in situations deemed detrimental to the student. The person requesting the interview may appeal the superintendent's decision to the division director or division director's designee.

c. Procedure.

(1) Whenever an interview is granted, at least one facility employee will be present for the entirety of the interview and will have the authority to terminate the interview anytime the employee believes the best interests of the student are not being served. Exceptions to this requirement will be made when the student's interview is with the student's own attorney or with state officials acting in an official capacity.

(2) The student shall be represented by legal counsel during any interview that is conducted to obtain information that will be or may be used in court.

d. Depositions. The superintendent may grant permission for written depositions according to the procedures for granting interviews. Voice recording of depositions will not be permitted. One copy of the deposition shall be submitted to the superintendent. This rule shall in no way restrict depositions ordered by the court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.5(218) Photographing and recording of students. A student's parent or legal representative may take photographs or make audio or video recordings of that student but shall not be authorized to take photographs or make recordings of any other student.

103.5(1) With the authorization of the superintendent or superintendent's designee, a student may take a photograph of another student with that student's consent.

103.5(2) Use of still or video cameras or voice recorders to photograph or record a student by anyone other than the student, parent, legal representative, or authorized employee will be allowed only with the prior authorization of the superintendent or superintendent's designee.

a. When granted, authorization to photograph or record will be for one specific use and will not extend to any other use.

b. Photographs and voice or video recordings of a student for public distribution will be permitted only with a signed informed consent from the superintendent and the individual's parent or legal representative.

c. The facility will maintain and implement policies and procedures for authorizing or denying photographing or recording of students. A person authorized to take photographs or recordings of a student shall make every effort to preserve the inherent dignity of the student and to preclude exploitation or embarrassment of the student or the family of the student.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.6(218) Employment of students. The facility will maintain and implement policies and procedures for the employment of students to help ensure the employer's compliance with all applicable state and federal laws. Employers that want to hire a student must obtain approval from the superintendent

or superintendent's designee. The employer, the superintendent or superintendent's designee, or the student shall have the right to terminate the employment at any time.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.7(218) Temporary home visits.

103.7(1) The facility will maintain and implement policies and procedures for the granting or denial of temporary home visits.

103.7(2) The superintendent or superintendent's designee and the student's juvenile court officer shall approve a temporary home visit before the visit is scheduled and only after the juvenile court officer has investigated and approved in writing the temporary home visit placement.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.8(218) Grievances. Any student who believes the student's rights have been violated by the facility or who has a complaint concerning the student's treatment at the facility may file a grievance. The student's parent, guardian, family, or legal representative may file a grievance on behalf of the student by submitting the grievance in writing to the superintendent. If the grievance directly concerns the superintendent, the grievance will be reviewed by the division director or the division director's designee. At any time during the grievance process, students retain their right to contact their attorney, juvenile court officer, the Iowa office of ombudsman, the division director or the division director's designee, regardless of the outcome determined by the facility or the superintendent.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.9(692A) Sex offender registration. A student who has been determined to be a sex offender as defined in Iowa Code section 692A.101(26) must register as a sex offender before release from the facility unless the juvenile court finds that the student is exempted from this requirement.

103.9(1) *Notification.* When a student who is a juvenile offender has not previously registered, the superintendent or superintendent's designee will provide the student with Form DCI-144, Notification of Registration Requirement, as required by the department of public safety in 661—subrule 83.3(1). Failure to provide a juvenile offender with the notification form does not relieve the juvenile offender of the duty to register with the Iowa sex offender registry.

103.9(2) *Exemption from registration.* To exempt a juvenile offender from registration, the language in the order of adjudication or disposition must clearly state that the juvenile offender is exempted from the registration requirement. If a court order is silent, the registration requirement applies.

a. If the order language does not clearly state that the juvenile offender is exempted from the registration process, then the responsibility rests with the juvenile offender to seek a clarifying order to be exempt from the registration process. A juvenile offender who seeks an exemption from the registration requirement has the obligation to prove that the juvenile offender deserves the exemption.

b. When the judicial decision is deferred, registration shall be assumed to be required until the court orders otherwise. If the court order defers the decision to grant an exemption from registration until the juvenile offender's treatment is completed, the language in the order should specify who tracks the case until the new court order is issued. If it is not clear who tracks the case, the juvenile offender is responsible to seek a clarifying order to be exempt from the registration process.

103.9(3) *Registration.* The superintendent or superintendent's designee will provide the juvenile offender with Form DCI-145, Sex Offender Registration, as required by the department of public safety in 661—subrule 83.3(2).

a. When the juvenile offender is released from the facility, the superintendent or superintendent's designee will submit the registration form to the division of criminal investigation of the department of public safety unless, by the time of release, the juvenile court finds that the juvenile should not be required to register as allowed by Iowa Code chapter 692A.

b. Copies of the sex offender registration will be maintained in the juvenile offender's file at the facility.

This rule is intended to implement Iowa Code section 692A.109.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.10(218) Alleged child abuse. The department will arrange for the investigation of any reported case of alleged child abuse. For cases in which the alleged perpetrator is a facility employee, contractor, or volunteer, or some other department employee, the investigation shall be conducted by an agency other than the department.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.11(233A) Cost of care. The facility will seek to recover a portion of the cost of care pursuant to Iowa Code section 233A.17. In determining the amount to be recovered:

103.11(1) The student will be allowed to retain a personal allowance equal to the personal allowance amount established by the Social Security Administration for the Supplemental Security Income program.

103.11(2) The amount recovered shall not exceed the actual cost of care.

103.11(3) The cost of care will be determined using the average per diem multiplied by the total days of care.

103.11(4) The superintendent may grant a one-time exception to recovery of up to $1,000 for a personal needs living expense if a student is being discharged and has no viable means of support upon release.

This rule is intended to implement Iowa Code section 233A.17.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.12(218) Buildings and grounds.

103.12(1) *Tours.* Tours of the facility will be subject to the prior approval of the superintendent or superintendent's designee.

103.12(2) *Public use.* Facility space is for the primary use of the facility. All public use of facility space shall require prior approval of the superintendent or superintendent's designee. Approval for use will be based on the order of requests received and on space availability after the programmatic and security needs of the facility are met.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

441—103.13(68B,218) Gifts and bequests. Gifts or bequests of money, clothing, books, games, recreational equipment or other items shall be made directly to the superintendent.

103.13(1) The superintendent or superintendent's designee will evaluate the gift or bequest in terms of the nature of the contribution to the facility program.

103.13(2) The superintendent will be responsible for accepting the gift or bequest and reporting it to the division director.

a. All monetary gifts or bequests will be acknowledged in writing to the donor.

b. All gifts or bequests with a value of $50 or more shall be reported to the Iowa ethics and campaign disclosure board pursuant to Iowa Code section 68B.22A.

This rule is intended to implement Iowa Code sections 68B.22A and 218.4.

[**ARC 0668D**, IAB 10/14/26, effective 12/1/26]

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CHAPTER 104
Reserved

TITLE XII
LICENSING AND APPROVED STANDARDS

CHAPTER 105
JUVENILE DETENTION AND SHELTER CARE HOMES

[Prior to 7/1/83, Social Services[770] Ch 105]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

441—105.1(232) Definitions.

"Administrator," when used for matters related to a certificate of approval or a certificate of license, means the administrator of the division of adult, children and family services.

"Authorized prescriber" means those persons identified in Iowa Code section 147.107 and Iowa Code chapter 154.

"Chemical restraint" means the use of chemical agents including psychotropic drugs as a form of restraint. The therapeutic use of psychotropic medications as a component of a service plan for a particular child is not considered chemical restraint.

"Child care worker" shall mean an individual employed by a facility whose primary responsibility is the direct care of the children in the facility.

"Coed facility" shall mean a facility which has both sexes in residence.

"Control room" shall mean a locked room in a juvenile detention home, used for the purpose of isolation or seclusion of a child. A control room shall not be allowed in a juvenile shelter care home.

"County or multicounty" shall mean that the governing body is a county board of supervisors or a combination of representatives from county boards of supervisors.

"Facility" shall mean a county or multicounty "juvenile detention home" or county or multicounty "juvenile shelter care home" as defined in Iowa Code section 232.2, and private juvenile detention and shelter care homes as defined in Iowa Code section 232.2 which do not meet the requirements of being "county or multicounty."

"Immediate family," for the purposes of this chapter, means persons who have a blood or legal relationship with the child.

"Mechanical restraint" means restriction by the use of a mechanical device of a child's mobility or ability to use the hands, arms or legs.

"Medication management and administration" means to properly tend to prescription and nonprescription medications, including, but not limited to: properly obtaining and storing medication; removing medication from its storage place; ensuring to the extent possible that the child ingests, applies, or uses the appropriate dosage at the appropriate time of day; and documenting the dosage and the time and date that the child ingested, applied, or used the medication.

"Nonprescription medication" means any drug or device that is not a prescription medication as defined in this chapter.

"Physical restraint" means direct physical contact required on the part of a staff person to prevent a child from hurting self, others, or property.

"Prescription medication" means a prescription drug as defined in Iowa Code section 155A.3(30).

"Prone restraint" means a physical restraint in which a child is held face down on the floor.

"Protective locked environment" means the same as defined in Iowa Code section 237.1(17).

"Schedule II medications" means those controlled substances identified in Iowa Code chapter 124.

"Staff" means any person providing care or services to or on behalf of the residents whether the person is an employee of the facility, an independent contractor or any other person who contracts with the facility, an employee of an independent contractor or any other person who contracts with the facility, or a volunteer.

"Time out" applies only to shelter care homes and means the temporary and short-term restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from

leaving, for the purpose of providing the resident an opportunity to regain self-control. Staff physically preventing the resident from leaving the time out area would be considered seclusion in control room conditions.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 0109D**, IAB 3/4/26, effective 5/1/26]

441—105.2(232) Buildings and grounds.

105.2(1) *Grounds.*

a. An outdoor play area of 75 square feet per child shall be provided.

b. The play area shall be identified and kept free from hazards that could cause injury to a child.

c. Rubbish and trash shall be kept separated from the play area.

d. The grounds shall be adequately drained.

105.2(2) *Buildings.*

a. All living areas shall:

(1) Have screens on windows used for ventilation.

(2) Be maintained in clean, sanitary conditions, free from vermin, rodents, dampness, noxious gases, and objectionable odors.

(3) Be in safe repair.

(4) Provide for adequate lighting when natural sunlight is inadequate.

(5) Have heating and storage areas separated from sleeping or play areas.

(6) Have walls and ceilings surfaced with materials that are asbestos free.

b. All sleeping rooms shall be of finished construction and provide a minimum of 60 square feet per child for multiple occupancy, 80 square feet per child for single occupancy, and not sleep more than four children per room.

(1) Facilities licensed prior to July 1, 1981, having a square foot area less than that required shall be considered to meet these standards.

(2) There shall be not more than four youths per room in shelter and two youths per room in detention. Sleeping areas shall be assigned on the basis of the individual child's needs for privacy and independence of group support. For detention facilities built prior to July 1, 1979, four youths per room in detention may be allowed provided the minimum square feet per child requirement is met. When a detention facility licensed prior to July 1, 1979, remodels or makes an addition after July 1, 1979, only two youths per room shall be allowed.

c. All rooms aboveground shall:

(1) Have a ceiling height of at least 7 feet, 6 inches.

(2) Have a window area of at least 8 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

d. All rooms belowground shall:

(1) Have a ceiling height of at least 6 feet, 8 inches.

(2) Have a window area of at least 2 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

(3) Have floor and walls constructed of concrete or other materials with an impervious finish and free from groundwater leakage.

105.2(3) *Bedrooms.*

a. Each child in care shall have a solidly constructed bed.

b. Sheets, pillowcases and blankets shall be provided for each child and shall be kept clean and in good repair.

c. Each child in care shall have adequate storage space for private belongings.

d. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

105.2(4) *Heating.*

a. The heating unit shall be so located and operated as to maintain the temperature in the living quarters at a minimum of 65 degrees Fahrenheit during the day and 55 degrees Fahrenheit during the night. Variances may be made in case of health problems. Temperature is measured at 24 inches above the floor in the middle of the room.

b. All space heaters involving the combustion of fuel, such as gas, oil or similar fuel, shall be properly vented to the outside atmosphere.

c. Neither rubber nor plastic tubing shall be used as supply lines for gas or oil heaters.

d. The heating and cooling plant shall be checked yearly and kept in a safe working condition at all times.

105.2(5) *Bathroom facilities.*

a. Bathrooms shall have an adequate supply of hot and cold running water.

b. Each bathroom shall be properly equipped with toilet tissue, towels, soap, and other items required for personal hygiene unless children are individually given such items. Paper towels, when used, and toilet tissue shall be in dispensers. Detention facilities shall provide items required for personal hygiene but shall not be required to keep items in the bathrooms.

c. Toilets and baths or showers shall provide for individual privacy.

d. There shall be a shower or tub for each ten children or portion thereof.

e. Tubs and showers shall have slip-proof surfaces.

f. At least one toilet and one lavatory shall be provided for each six children or portion thereof.

g. Toilet facilities shall be provided with natural or artificial ventilation capable of removing odors and moisture.

h. Toilet facilities adjacent to a food preparation area shall be separated completely by a windowless door that completely fills the doorframe.

i. All toilet facilities shall be kept clean.

j. When more than one stool is used in one bathroom, partitions providing privacy shall be used.

k. Toilets, wash basins, and other plumbing or sanitary facilities shall be maintained in good operating condition.

105.2(6) *Food preparation and storage.*

a. Cracked dishes and utensils shall not be used in the preparation, serving, or storage of food.

b. Storage areas for perishable foods shall be kept at 45 degrees Fahrenheit or below.

c. Storage areas for frozen food shall be kept at zero degrees Fahrenheit or below.

d. Food that is to be served hot shall be maintained at 140 degrees Fahrenheit or above.

e. Food that is to be served cold shall be maintained at 45 degrees Fahrenheit or less.

f. The kitchen and food storage areas shall be kept clean and neat. Food shall not be stored on the floor.

g. The floor and walls shall be of smooth construction and in good repair.

105.2(7) *Personnel handling food.*

a. Shall be free of infection that might be transferred while preparing or handling food.

b. Shall be clean and neatly groomed.

c. Shall wear clean clothes.

d. Shall not use tobacco in any form while preparing or serving food.

105.2(8) *Dishwashing facilities.*

a. Manual dishwashing will be allowed in facilities that normally serve 15 or less people at one meal.

b. Automatic or commercial dishwashers shall be used in facilities normally serving more than 15 people at one meal, as long as the following conditions are met:

(1) When chemicals are added for sanitation purposes, they shall be automatically dispensed.

(2) Machines using hot water for sanitizing must maintain the wash water at least 150 degrees Fahrenheit and rinse water at a temperature of at least 180 degrees Fahrenheit or a single temperature machine at 165 degrees Fahrenheit for both wash and rinse.

(3) All machines shall be thoroughly cleaned and sanitized at least once each day or more often if necessary to maintain satisfactory operating condition.

c. Soiled and clean dish table areas shall be of adequate size to accommodate the dishes for one meal.

d. All hand-held food preparation and serving equipment shall be cleaned and sanitized following each meal. Dispensers, urns and similar equipment shall be cleaned and sanitized daily.

105.2(9) *Foods not prepared at site of serving.*

a. The place where food is prepared for off-site serving shall conform with all requirements for on-site food preparation.

b. Food shall be transported in covered containers or completely wrapped or packaged so as to be protected from contamination.

c. During transportation, and until served, hot foods shall be maintained at 140 degrees Fahrenheit or above and cold food maintained at 45 degrees Fahrenheit or below.

105.2(10) *Milk supply.* When fluid milk is used, it shall be pasteurized Grade "A."

105.2(11) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system.

105.2(12) *Private water supplies.*

a. Maintenance and operation. Each privately operated water supply shall be maintained and operated in a manner that ensures safe drinking water. Each water supply used as part of a facility shall be annually inspected and evaluated for deficiencies that may allow contaminants access to the well interior. Items such as open or loose well caps, missing or defective well vents, poor drainage around the wells, and the nearby storage of potential contaminants shall be evaluated. All deficiencies shall be corrected by a well contractor certified by the state within 30 days of discovery.

b. Evaluation and water testing. As part of the inspection and evaluation, water samples shall be collected and submitted by the local health sanitarian or a well contractor certified by the state to the state hygienic laboratory or other laboratory certified for drinking water analysis by the department of natural resources. The minimum yearly water analysis shall include coliform bacteria and nitrate (NO_3^-) content. Total arsenic testing shall be performed once every three years. The water shall be deemed safe when there are no detectible coliform bacteria, when nitrate levels are less than 10 mg/L as nitrogen, and when total arsenic levels are 10 µg/L or less. A copy of the laboratory analysis report shall be provided to the department within 72 hours of receipt by the water supply.

c. Multiple wells supplying water. When the water supply obtains water from more than one well, each well connected to the water distribution system shall meet all of the requirements of these rules.

d. Deficiencies. When no apparent deficiencies exist with the well or its operations and the water supply is proven safe by meeting the minimum sampling and analysis requirements, water safety requirements have been met. Wells with deficiencies that result in unsafe water analysis require corrective actions through the use of a well contractor certified by the state.

e. When water is proven unsafe. When the water supply is proven unsafe by sampling and analysis, the facility shall immediately provide a known source of safe drinking water for all water users and hang notification at each point of water use disclosing the water is unsafe for drinking water uses. In addition, the facility shall provide a written statement to the department disclosing the unsafe result and detail a plan on how the water supply deficiencies will be corrected and the supply brought back into a safe and maintained condition. The statement shall be submitted to the department within ten days of the laboratory notice. All corrective work shall be performed and the water supply sampled and analyzed again within 45 days after any water test analysis report that indicates the water supply is unsafe for drinking water uses.

f. Water obtained from another source through hauling and storage must meet the requirements of the department of natural resources.

105.2(13) *Heating or storage of hot water.* Each tank used for the heating or storage of hot water shall be provided with a pressure and temperature relief valve.

105.2(14) *Sewage treatment.*

a. Facilities shall be connected to public sewer systems where available.

b. Private disposal systems shall be designed, constructed, and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

105.2(15) *Garbage storage and disposal.*

a. A sufficient number of garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly-tight, leakproof, and rodent proof and shall be maintained in a sanitary condition.

105.2(16) *General.*

a. Facilities shall take sufficient measures to ensure the safety of the children in care.

b. Stairways, halls and aisles shall be of substantial nonslippery material, shall be maintained in a good state of repair, shall be adequately lighted and shall be kept free from obstructions at all times. All stairways shall have handrails.

c. Radiators, registers and steam and hot water pipes shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

d. Fuse boxes shall be inaccessible to children.

e. Facilities shall have written procedures for the handling and storage of hazardous materials.

f. Firearms are prohibited in shelter care and detention facilities.

g. All swimming pools shall conform to state and local health and safety regulations. Adult supervision shall be provided at all times when children are using the pool.

h. The facility shall have policies regarding fishing ponds, lakes or any bodies of water located on or near the institution grounds and accessible to the children.

105.2(17) *Emergency evacuation and safety procedures.* Upon admission, all children shall receive instruction regarding evacuation and safety procedures. All living units utilized by children shall have a posted plan for evacuation and safety procedures regarding severe weather events, fire or other natural or man-made disasters. Practice fire drills shall be held monthly, and severe weather drills shall be held twice annually.

105.2(18) *Fire inspection.* Each facility shall procure an annual fire inspection approved by the state fire marshal and shall meet the recommendations thereof.

105.2(19) *Local codes.* Each facility shall meet local building, zoning, sanitation and fire safety ordinances. Where no local standards exist, state standards shall be met.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.3(232) Personnel policies.

105.3(1) *Policies in writing.* The following personnel policies and practices of the agency relating to a specific facility shall be described in writing and accessible to staff upon request:

a. Affirmative action and equal employment opportunity policies and procedures covering the hiring, assignment and promotion of employees.

b. Job descriptions for all positions.

c. Provisions for vacations, holidays and sick leave.

d. Effective, time-limited grievance procedures allowing the aggrieved party to bring the grievance to at least one level above that party's supervisor.

e. Authorized procedures, consistent with due process for the suspension and dismissal of an employee for just cause.

f. Written procedures for annual employee evaluation shall be in place for each facility and available to all staff upon request.

105.3(2) *Health of employees.* Each staff person who has direct client contact or is involved in food preparation shall be tested for tuberculosis and have had a physical examination within six months prior to hiring, unless the staff can produce valid documentation of the physical and tuberculosis test from within the previous three years. Physical examinations shall be completed at least every three years thereafter, or whenever circumstances require them more frequently. Evidence of these examinations or tests shall be included in each personnel file. The examinations or tests shall be completed by one of the following:

a. A physician as defined in Iowa Code section 135.1(4);

b. An advanced registered nurse practitioner who is registered with and certified by the Iowa board of nursing to practice nursing in an advanced role; or

c. A physician assistant licensed under Iowa Code chapter 148C.

105.3(3) *Personnel records.* A record shall be maintained by the facility as applicable for each volunteer who has direct responsibility for a child or access to a child when the child is alone and for each employee. The record shall contain at least the following:

a. Name, address, and social security number of the volunteer or employee.

b. A job application containing sufficient information to justify the initial and current employment.

c. Verification of education and experience. Applicants for positions having educational requirements shall be permanently employed only after the facility has obtained a certified copy of the transcript, diploma, or verification from the school or supervising agency. Applicants for positions having experience requirements shall be permanently employed only after the facility has obtained verification from the agency supervising the experience.

d. Verification of license. Applicants for positions requiring licenses shall be permanently employed only after the facility has obtained written verification of their licenses. Evidence of renewal of licenses as required by the licensing agency shall be maintained in the personnel record.

e. References. At least two written references or documentation of oral references shall be contained in the volunteer's or employee's personnel record. In case of unfavorable references, there shall be documentation of further checking to ensure that the person will be a reliable volunteer or employee.

f. A written, signed and dated statement which discloses any substantiated instances of child abuse, neglect or sexual abuse committed by the volunteer or job applicant.

g. Documentation of the submission of Form 470-0643, Request for Child Abuse Information, to the central abuse registry, the registry response, the department's evaluation of any abuse record discovered, and a copy of Form 470-2310, Record Check Evaluation, if the volunteer or staff person has completed and submitted it.

h. A written, signed and dated statement furnished by the new volunteer or applicant for employment which discloses any convictions of crimes involving the mistreatment or exploitation of a child.

i. Documentation of a check with the Iowa department of public safety on all new volunteers and applicants for employment using Form 595-1396, DHS Criminal History Record Check, Form B; a copy of the department's evaluation of any criminal record discovered; and a copy of Form 470-2310, Record Check Evaluation, if the volunteer or applicant has completed and submitted it.

j. Documentation of any checks with the Iowa department of public safety for persons hired before July 1, 1983, for whom the agency has reason to suspect a criminal record.

k. Current information relative to work performance evaluation.

l. Records of preemployment health examination or a record of a health report as required in 105.3(2) as well as a written record of subsequent health services rendered to an employee as necessary to ensure that all facility employees are physically able to perform their duties.

m. Information on written current reprimands or commendations.

n. Position in the agency, and date of employment.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 9829B**, IAB 11/2/11, effective 1/1/12; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.4(232) Procedures manual. Rescinded **ARC 4793C**, IAB 12/4/19, effective 1/8/20.

441—105.5(232) Staff.

105.5(1) *Number of staff.*

a. Generally. A sufficient number of child care staff shall be on duty at all times so as to provide adequate coverage. The number of staff required will vary depending on the size and complexity of the program. All facilities shall have at least one staff person on duty. A minimum staff-to-child ratio of one child care worker to five children shall be maintained at all times children are awake and present in the facility and during supervised outings. All child care staff shall be at least 18 years of age.

b. On-call system. There shall be an on-call system to provide supervisory consultation. There shall be a written plan documenting this system.

c. Reserved.

d. Night hours. At night, there shall be a staff person awake in each living unit and making regular visual checks throughout the night. The visual checks shall be made at least every hour in shelter care and every half hour in detention. A log shall be kept of all checks, including the time of the check and any significant observations. The minimum staff-to-child ratio must be maintained at 1:16 during the overnight shift.

105.5(2) *Staff composition.* The composition of the program staff shall be determined by the facility, based on an assessment of the needs of the children being served, the facility's goals, the programs provided, and all applicable federal, state and local laws and regulations.

105.5(3) *Staff development.* Staff development shall be appropriate to the size and nature of the facility. There shall be a written plan for staff training that includes:

a. Orientation for all new employees, to acquaint them with the philosophy, organization, program practices, and goals of the facility.

b. Training of new employees in areas related to their job assignments.

c. Provisions in writing for all staff members to improve their competency through such means as:

(1) Attending staff meetings;

(2) Attending seminars, conferences, workshops, and institutes;

(3) Visiting other facilities;

(4) Access to consultants;

(5) Access to current literature, including books, monographs, and journals relevant to the facility's services.

d. There shall be an individual designated responsible for staff development and training, who will complete a written staff development plan which shall be updated annually.

105.5(4) *Organization and administration.* Whenever there is a change in the name of the facility, the address of the facility, the executive, or the capacity, the information shall be reported to the department. A table of organization including the identification of lines of responsibility and authority from policymaking to service to clients shall be available to the licensing staff. An executive director shall have full administrative responsibility for carrying out the policies, procedures and programs.

105.5(5) *Record checks.* Record checks are required for an entity being considered for a certificate of approval or a certificate of license or employment on a facility campus where children reside to determine whether any founded child abuse reports, convictions for crimes for the mistreatment or exploitation of children, or criminal convictions exist related to the person having been placed on a sex offender registry. The facility shall not employ or use any staff person if that person has been convicted of a crime involving the mistreatment or exploitation of a child. The facility shall not employ or use any staff person if that person has a record of a criminal conviction or founded child abuse report unless the department has evaluated the crime or abuse and determined that the crime or abuse does not merit prohibition of a certificate of approval or a certificate of license, volunteering or employment. For each person working in a shelter care home on a facility campus where children reside, fingerprints shall be provided to the department of public safety for submission through the state criminal history repository to the United States Department of Justice, Federal Bureau of Investigation, for a national criminal history check. Fingerprinting, for the purpose of a national criminal history check, is required for any entity being considered for a certificate of approval or a certificate of license or employment by an approved entity on a facility campus where children reside.

a. If a record of criminal conviction or founded child abuse exists, the person shall be offered the opportunity to complete and submit Form 470-2310, Record Check Evaluation.

b. In its evaluation, the department shall consider:

(1) The nature and seriousness of the crime or founded abuse in relation to the employment or volunteer position sought;

(2) The time elapsed since the commission of the crime or founded abuse;

(3) The circumstances under which the crime or founded abuse was committed;

(4) The degree of rehabilitation; and

(5) The number of crimes or founded abuses committed by the person involved.

105.5(6) *Record check procedure.* Each entity being considered for a certificate of approval or a certificate of license or employment by an approved entity on a facility campus where children reside shall be checked for all of the following:

a. Records with the Iowa central abuse registry;

b. Records with the Iowa division of criminal investigation;

c. Records with the Iowa sex offender registry;

d. Records with the child abuse registry of any state where the person has lived during the past five years; and

e. Fingerprints provided to the department of public safety for submission through the state criminal history repository to the United States Department of Justice, Federal Bureau of Investigation, for a national criminal history check.

105.5(7) *Evaluation of record.* If the entity for whom background checks are required has a record of founded child or dependent adult abuse, a criminal conviction, or placement on a sex offender registry, the department shall complete an evaluation to determine that the abuse, criminal conviction, or placement on a sex offender registry does not warrant prohibition of a certificate of approval or a certificate of license or employment by an approved entity on a facility campus where children reside.

105.5(8) *Evaluation form.* The entity with the founded child or dependent adult abuse or criminal conviction report shall complete and return record check evaluation forms required by the department within ten calendar days of the date of receipt to be used to assist in the evaluation.

105.5(9) *Evaluation decision.* The department shall conduct the evaluation and issue a notice of decision in writing to the requesting entity.

[**ARC 9829B**, IAB 11/2/11, effective 1/1/12; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.6(232) Intake procedures.

105.6(1) *Admissions.* Admission to shelter care or detention shall be in accordance with Iowa Code sections 232.20, 232.21 and 232.22. In no case shall a youth be admitted to detention or shelter care when the resulting admission would exceed the facility's approved client capacity. The facility and referring agency shall agree upon service responsibilities at the time of admission.

105.6(2) *Agency or court order placement.* Each agency or court placing a child in a facility shall make available to the facility the following:

a. A placement agreement should accompany the child.

When this is not possible, a copy of the placement agreement shall be provided the facility within 24 hours.

b. For court-ordered placements, a copy of the court order authorizing placement shall be provided to the facility within 48 hours.

c. When the child is in the facility more than four days, the following information shall be requested by the facility if not yet received.

(1) All available psychological and psychiatric tests and reports concerning the child.

(2) Any available family social history.

(3) Any available school information.

105.6(3) *Self-referrals.* Any child admitting self to a facility shall be provided appropriate services. The facility shall notify the child's parents, guardian or the juvenile court as soon as possible concerning the child's admission to the facility but in any event the notification shall take place within 48 hours after the child's admission. Self-referrals shall not be accepted for placement in detention.

105.6(4) *Person responsible.* Each agency shall designate who has the authority to do intake. This may include anyone trained in intake procedures and who is designated to do intake.

105.6(5) *Intake sheet.* An intake sheet shall be completed on each child containing at least the information specified in 105.17(2).

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.7(232) Assessments.

105.7(1) *Personal.* At the time of intake and throughout a child's stay, individual needs will be identified by staff. The initial and ongoing determination of each child's needs will be based on written and verbal information from referral sources, observable behavior at intake, initial interview with the youth or family, school contacts, physical examination, and other relevant materials. The individual assessment shall provide the basis for development of a care plan for each youth.

105.7(2) *Educational.* An educational assessment shall be developed by the staff and referring worker for each child. When appropriate, other agencies such as the public schools and the area education agency shall be involved.

441—105.8(232) Program services.

105.8(1) *Service plan.* There shall be a written service plan developed for each resident remaining in the facility over four days and completed according to the time frames identified for the contracted service. The service plan will be based on individual needs determined through the assessment of each youth. The service plan shall be developed in consultation with child care services, probation services, social services and educational, medical, psychiatric and psychological personnel as appropriate. The plan shall include:

a. Identification of specific needs;

b. Description of planned service;

c. Which staff person(s) will be responsible for each element of the plan;

d. Where services are to occur;

e. Frequency of activities or services.

105.8(2) *Educational programs.* All children currently enrolled in a school shall continue in that school when possible, or in an appropriate alternative. Where educational assessments indicate an educational need for a child not currently enrolled in public schools, an alternative shall be developed in cooperation with public schools, area education agency, and the referring worker. When an educational program is established within the facility it shall meet the educational and teaching standards established by the state department of public instruction. A child should be compelled to participate in an educational program only in compliance with the compulsory education law, Iowa Code chapter 299.

105.8(3) *Daily program.* The daily program shall be planned to provide a consistent, well structured, yet flexible framework for daily living, and shall be periodically reviewed and revised as the needs of the individual child or the living group change.

Attention shall be given to the special nature of the facility population and its resulting stresses, for example, rapid turnover in population and minimal screening at intake.

105.8(4) *Optional services.* When a facility provides services in addition to those required by these rules, they shall be clearly defined in writing.

105.8(5) *Recreation program.* The facility shall provide adequately designed and maintained indoor and outdoor activity areas, equipment, and equipment storage facilities appropriate for the age group which it serves. There shall be a variety of activity areas and equipment so that all children can be active participants in different types of individual and group sports and other motor activity.

a. Games, toys, equipment, and arts and crafts materials shall be selected according to age, number of children, and with consideration of the needs of children to engage in both active and quiet play. All materials shall be of a quality to ensure safety and shall be of a type which allows imaginative play and creativeness.

b. Shelter care homes shall plan and carry out efforts to establish and maintain workable relationships with the community recreational resources. The facility staff shall enlist the support of these resources to provide opportunities for children to participate in community recreational activities.

105.8(6) *Health care.*

a. Health assessment at intake. Facility staff shall review each child's health status at intake. The purpose of this preliminary review is to identify medication needs and problems that need immediate medical attention. Within seven days of intake, all reasonable efforts shall be made to perform a more comprehensive health assessment on each child who has not had a comprehensive health assessment within the past year. If the assessment cannot be performed within seven days, it shall be arranged for the earliest possible time, and the reasons for the delay shall be documented. A registered nurse, an advanced registered nurse practitioner, a physician assistant, or a physician shall perform the comprehensive health assessment.

b. Existing health needs. Facilities shall provide or secure medical treatment for a child's illnesses and injuries that come to the facility's attention during the child's stay.

c. Monitoring side effects of medications. Facilities shall monitor each child's use of medications and shall inform the authorized prescriber if adverse reactions are noted.

d. Sharing medical information. Facilities shall share information about significant changes in medical status with the child's caseworker and parents or guardian. Discharge information shall include information about significant medical changes that occurred while the child was at the facility.

105.8(7) *Counseling program.* Counseling services shall be related to the immediate problem, daily living skills, peer relationships, educational opportunities, vocational opportunities, future planning and preparation for placement, family counseling, and any other factors identified in the individual care plan. Counseling shall be done by appropriate staff personnel.

105.8(8) *Dietary program.* The facility shall provide properly planned, nutritious and inviting food and take into consideration the dietary and health needs of children. The facility shall follow all dietary recommendations prescribed by medical personnel or a dietitian licensed in the state of Iowa.

105.8(9) *Liability.* Juvenile shelter care homes that apply the reasonable and prudent parent standard reasonably and in good faith in regard to a child in foster care shall have immunity from civil or criminal liability which might otherwise be incurred or imposed. This subrule shall not remove or limit any existing liability protection afforded under any other law.

105.8(10) *Safety, protection, and well-being of children in care.* Facilities shall develop and follow written policies that assure the safety, protection, and well-being of children in care. Policies shall address, but not be limited to, the following:

a. Supportive leadership of the facility that promotes protecting each child from abuse or bullying from other children and staff.

b. Defining the facility's culture to reduce the use of unnecessary restraint.

c. Clear definitions of unsafe behavior and the emergency situations when it is appropriate to use physical interventions.

d. Staff training and development that give staff confidence that they are supported by leadership with proper supervision and ongoing access to information about best practices and evidence-based approaches to care.

e. Adequate supervision of children while the children are using any hazardous or dangerous objects or equipment and when children are using the Internet or other social media.

f. The social, cultural, and developmental needs of children in care.

g. Defining protective locked environment and how it is utilized to provide safety and security for children.

105.8(11) *Staff duties.* The staff duties shall include, but not be limited to, the following:

a. Providing a supportive atmosphere for each child.

b. Providing for coordination of internal and external activities of each child as needed.

c. Providing leadership and guidance to each child as needed.

d. Being responsible for overseeing and maintaining the general health and well-being of each child.

e. Supervising all living activities.

f. At all times, knowing where the children are and where they are supposed to be to ensure ongoing safety.

g. Providing for a liaison with the referring agency.

h. Monitoring and recording behavior on a daily basis.

105.8(12) *Volunteers.* A facility that utilizes volunteers to work directly with a particular child or group of children shall have a written plan for using volunteers. This plan shall be given to all volunteers. The plan shall indicate that all volunteers shall:

a. Be directly supervised by a paid staff member.

b. Be oriented and trained in the philosophy of the facility and the needs of children in care and methods of meeting those needs.

c. Be subject to character, reference, and record check requirements as described in this chapter.

[**ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 0109D**, IAB 3/4/26, effective 5/1/26]

441—105.9(232) Medication management and administration. The facility shall have and follow written policies and procedures governing the methods of handling prescription drugs and over-the-counter drugs within the facility. No prescription or narcotic drugs are allowed in the facility without the authorization of a licensed physician or other prescriber authorized by law. Only drugs which have been approved by the federal Food and Drug Administration for use in the United States may be used. No experimental drugs may be used.

105.9(1) *Obtaining prescription medications.* Facilities shall permit prescription medications to be brought into the facility for a child.

a. Prescription medication in its original container, clearly labeled and prescribed for the child, may be accepted as legitimate prescription medication for the child. The label serves as verification that the medication was ordered by an authorized prescriber. Medication shall be prescribed by a provider authorized to prescribe the medication. Medication provided to residents shall be dispensed only from a licensed pharmacy in the state of Iowa in accordance with the pharmacy laws in the Iowa Code, from a licensed pharmacy in another state according to the laws of that state, or by a licensed physician.

b. Facilities shall review size, shape, color, and dosages and contact the identified pharmacy or authorized prescriber to confirm legitimacy if contraband is suspected.

105.9(2) *Obtaining nonprescription medications.* Shelter and detention facilities shall maintain a supply of standard nonprescription medications for use for children residing at the facility. Examples of standard nonprescription medications include cough drops and cough syrups, aspirin substitutes and other pain control medication, poison antidote, and diarrhea control medication.

a. All nonprescription medications kept on the premises for the use of residents shall be preapproved annually by a licensed pharmacist or an authorized prescriber.

b. Facilities shall maintain a list of all preapproved nonprescription medications. The list shall indicate standard uses, standard dosages, contraindications, side effects, and common drug interaction warnings. The facility administrator or the administrator's designee shall be responsible for determining the scope of the list and brands and types of medications included.

c. Only nonprescription medications on the preapproved list shall be available for use. However, the facility administrator or the administrator's designee, in consultation with an authorized prescriber or licensed pharmacist, may approve use of a nonprescription medication that is not on the preapproved list for a specific child.

105.9(3) *Storing medications.* Prescription and nonprescription medications shall be stored in a locked cabinet, a locked refrigerator, or a locked box within an unlocked refrigerator.

a. Schedule II medications shall be stored in a locked box within a locked cabinet. Nothing other than Schedule II medications shall be stored in the locked box. Schedule II medications requiring refrigeration also shall be maintained within a double-locked container separate from food and other items.

b. The facility administrator shall determine distribution and maintenance of keys or other access to the medication storage cabinets and boxes.

c. A shelter facility administrator or the administrator's designee may preapprove shelter staff to carry prescription or nonprescription medications with them temporarily for use at sites away from the facility.

105.9(4) *Labeling medications.* Schedule II medications and prescription medications shall be maintained in their original containers, clearly labeled by an authorized prescriber and prescribed for the child. Sample prescription medications shall be accompanied by a written prescription. Nonprescription medications shall be maintained as purchased in their original containers.

105.9(5) *Administering Schedule II medications.* Only staff who have completed a medication management course shall be allowed to administer Schedule II medications.

105.9(6) *Administering prescription and nonprescription medications.* The facility administrator shall determine and provide written authority as to which staff may administer prescription and nonprescription medications.

a. Prescription medications shall be administered only in accordance with the orders of the authorized prescriber. Nonprescription medications shall be administered by following the directions on the label.

b. The facility administrator or the administrator's designee may allow a child to self-administer prescription medication with written authorization by the authorized prescriber. The facility shall have written policies relating to self-administration of prescription and nonprescription medication. The facility shall require documentation if the child self-administers a medication.

105.9(7) *Documenting errors in administering medications.* All errors in administering prescription and nonprescription medications shall be documented. Facilities shall review and take appropriate action to ensure that similar errors do not recur.

105.9(8) *Medication for discharged residents.* When a child is discharged or leaves the facility, the facility shall turn over to a responsible agent Schedule II medications and prescription medications currently being administered. The facility may send nonprescription medications with the child as needed. The facility shall document in the child's file:

a. The name, strength, dosage form, and quantity of each medication.

b. The signature of the facility staff person turning over the medications to the responsible agent.

c. The signature of the responsible agent receiving the medications.

105.9(9) *Destroying outdated and unused medications.* Unused Schedule II medications and prescription medications may not be kept at the facility for more than 15 days after the child has left the facility and the Schedule II medications and prescription medications shall be destroyed by the administrator or the administrator's designee in the presence of at least one witness. Outdated, discontinued, or unusable nonprescription medications shall also be destroyed in a similar manner. The person destroying the medication shall document:

a. The child's name.

b. The name, strength, dosage form, and quantity of each medication.

c. The date the medication was destroyed.

d. The names and signatures of the witness and staff person who destroyed the medication.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.10(232) Control room—juvenile detention home only.

105.10(1) *Written policies.* When a juvenile detention facility uses a control room as part of its service, the facility shall have written policies regarding its use and the facility director shall complete Form 470-0700, Evaluation and Recommendation to Operate a Control Room. The policy shall:

a. Specify the behaviors resulting in control room placement.

b. Delineate the staff members who may authorize its use as well as procedures for notification of supervisory personnel.

c. Document in writing behaviors leading to control room placement and the nature of the agreement reached with the child that will allow the child to return to the living unit.

105.10(2) *Physical requirements.* The control room shall be designed to ensure a physically safe environment that:

a. Has all switches controlling lights and ventilation outside of the room.

b. Allows for total observation of the child at all times.

c. Has protected recessed ceiling light.

d. Has no electrical outlets in the room.

e. Is properly heated, cooled and ventilated.

f. Has all doors, ceilings and walls constructed of strength and materials as to prevent damage to the extent that no harm could come to the child.

g. When a window is present, it is secured and protected in such a manner as to prevent harm to the child.

h. Is a minimum of 6 feet by 9 feet in size with at least a 7½ foot ceiling.

105.10(3) *Use.* A control room shall be used only when a less restrictive alternative to quiet or allow the child to gain control has failed. Utilization of the control room shall be in accordance with the following policies:

a. No more than one child shall be in the control room at any time.

b. There shall be provision for visual observation of the child at all times, regardless of the child's position in the room.

c. The control room should be checked thoroughly for safety and the absence of contraband prior to placing a child in the room.

d. The child shall be thoroughly checked before placement in the control room and all potentially injurious objects removed from such child including shoes, belts, pocket items, and similar items. The staff member placing the child in the control room shall document such check.

e. In no case shall all clothing or underwear be removed and the child shall be provided sufficient clothing to meet seasonal needs.

f. A staff member shall always be positioned outside of the control room. Visual and auditory observations of the child's behavior and condition shall be recorded at five-minute intervals, and a complete written report shall be documented in the child's file by the end of the staff person's work shift.

g. The child shall not remain in the control room longer than 1 hour except in consultation with and approval from the supervisor. Documentation in the child's case record shall include the time in the control room, the reasons for the control, and the reasons for the extension of time. Use of the control room for a total of more than 12 hours in any 24-hour period shall occur only in consultation with the referring agency or court. In no case shall a child be in a control room for a period longer than 24 hours.

h. The child's parents, referring worker, and the child's attorney shall be notified when the control room is used for more than a total of 30 minutes in any 24-hour period.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.11(232) Clothing. All children shall have clothing that is suited to existing climate and seasonal conditions and is clean, dry and in good repair.

441—105.12(232) Staffings. The staff shall be available to participate in staffings or upon request to provide a written summary of the child's progress and behavior while in the facility program. Written recommendations regarding future planning and placement shall be provided to the referring agency or court upon request. Staff shall be available to discuss recommendations with the child's parent or guardian.

441—105.13(232) Child abuse. Written policies shall prohibit mistreatment, neglect or abuse of children and specify reporting and enforcement procedures for the facility. Alleged violations shall be reported immediately to the director of the facility and appropriate department of human services personnel. Any employee for whom there is a substantiated instance of child abuse or failure to report child abuse shall be subject to the agency's policies concerning dismissal.

441—105.14(232) Daily log. The facility shall maintain a daily log to generally record noteworthy occurrences regarding the children in care. Problem areas or unusual behavior for specific children shall be recorded in individual children's records.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.15(232) Children's rights.

105.15(1) *Policies in writing.* All policies and procedures covered in this rule shall be in writing and provided to the child upon admission and made available to the child's parent or guardian upon request. If the child remains in care over four days, the policies and procedures shall be provided to the parent or guardian. The rationale and circumstances of any deviation from these policies shall be discussed with the child's parents or guardian and the referring worker, documented, and placed in the child's case record.

105.15(2) *Confidentiality.* Information regarding children and their families shall be kept confidential and released only with proper written authorization.

105.15(3) *Communication.*

a. Unless specifically regulated by the court, visitation shall be allowed with members of the child's immediate family.

b. Family visits shall be monitored only to the extent necessary to ensure the child's safety and facility security. Rationale for monitoring shall be documented in the child's record.

c. The child shall be permitted to communicate privately with legal counsel and the referring worker.

d. The child shall be allowed to conduct telephone conversations with family members. Telephone calls shall be monitored only to the extent necessary to ensure the child's well-being and facility security.

Rationale for monitoring a child's conversation shall be documented in the child's record. Incoming calls may be screened by staff to verify the identity of the caller before approval is given.

e. The staff shall not open or read residents' mail. The child shall be allowed to send and receive mail. The facility may require the child to open incoming mail in the presence of a staff member when the mail is suspected to contain contraband articles, or to contain money that should be receipted and deposited.

f. When limitations on visitation or other communications are indicated, they shall be determined with the participation or knowledge of the child, family or guardian, and the referring worker. All restrictions shall have specific bases which shall be made explicit to the child and family and documented in the child's case record.

105.15(4) *Privacy.* Reasonable provisions shall be made for the privacy of residents.

441—105.16(232) Discipline.

105.16(1) *Generally.* A facility shall have written policies regarding methods used for control and discipline of children which shall be available to all staff and to the child's family. Discipline shall not include withholding of basic necessities such as food, clothing, or sleep. Discipline shall not be used for anyone other than a child whose actions resulted in consequences. Group discipline shall not be used because of actions of an individual child or other children. Agency staff shall be in control of and responsible for discipline at all times.

105.16(2) *Corporal punishment prohibited.* The facility shall have a policy that clearly prohibits staff or the children from utilizing corporal punishment as a method of disciplining or correcting children. This policy shall be communicated in writing to all staff of the facility.

105.16(3) *Physical restraint.* The use of physical restraint shall be employed only to prevent the child from injury to self, to others, or to property. Physical restraint must be conducted with the child in a standing position whenever possible.

a. No staff person shall use any restraint that obstructs the airway of a child.

b. Prone restraint is prohibited. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint.

c. If a staff person physically restrains a child who uses sign language or an augmentative mode of communication as the child's primary mode of communication, the child shall be permitted to have the child's hands free of restraint for brief periods unless the staff person determines that such freedom appears likely to result in harm to the child, others, or property.

d. The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the child's rights and to ensure safety shall be clearly set forth in the child's record by the responsible staff persons.

e. A child known to be pregnant may not be restrained during labor, delivery, and postpartum recovery, unless credible, reasonable grounds exist to believe the detainee presents an immediate and serious threat of hurting herself, staff, or others.

f. A facility may not use abdominal restraints, leg and ankle restraints, wrist restraints behind the back, and four-point restraints on a known pregnant child, unless credible, reasonable grounds exist to believe the detainee presents an immediate and serious threat of hurting herself, staff, or others or reasonable grounds exist to believe the detainee presents an immediate and credible risk of escape that cannot be reasonably minimized through any other method.

105.16(4) *Room confinement—juvenile detention home only.* A juvenile detention home may confine a child to the child's room during normal sleeping hours or for disciplinary reasons if the facility has written policies and procedures that include, but are not limited to, the reasons for and time limitations of the confinement.

105.16(5) *Time out—juvenile shelter care home only.*

a. A resident in time out must never be physically prevented from leaving the time out area.

b. Time out may take place away from the area of activity or from other residents, such as in the resident's room, or in the area of activity of other residents.

c. Staff must monitor the resident while the resident is in time out.

105.16(6) *Written policies.* The facility shall provide to the child written policies specifying inappropriate behaviors, reasonable consequences for misconduct, and due process procedures available to the child. Upon request, the above information shall be provided to the child's parent or guardian and referring worker.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.17(232) Case files.

105.17(1) *Generally.* For the purpose of promoting a uniformity of program for all facilities and as an aid to the department of human services in determining its approval of a facility all facilities shall establish and maintain for inspection case files on each child.

105.17(2) *Face sheet.* For all children, a face sheet containing the following information shall be completed.

a. Full name, current address, and date of birth.

b. Parent's(s') full name(s).

c. Parent's(s') address and telephone number.

d. Religious preference of the child and also parent, if available.

e. Statement of who has legal custody and guardianship.

f. Name of referring worker and agency making the referral.

g. Telephone number and address of referring agency or court.

h. Name, address, and telephone number of the child's attorney.

105.17(3) *Written summary.* When a written summary has been requested under 441—105.12(232), a copy shall be placed in the child's record.

105.17(4) *Documentation.* The following information shall be documented in each child's record:

a. Appropriate notes on all significant contacts by staff with parents, referral person and other collateral contacts.

b. A summary related to discharge from the facility including:

(1) The name, address, and relationship of the person or agency to whom the child was discharged.

(2) The discharge summary (as included in the service plan).

(3) Final disposition of a child's medications as applicable.

(4) Identification of who transported the child and destination postdischarge.

105.17(5) *Other information.* The following information shall be requested when the child remains in the facility more than four days and, when available, shall be placed in the child's record.

a. Current family history or social history.

b. Case plans submitted by the referring agency or orders of the court.

c. Psychological and psychiatric records; copies of all available testing performed plus notes and records of contact with the child.

d. Medical.

(1) A record of all illnesses, immunizations, communicable diseases and follow-up treatment.

(2) Medical and surgical releases or authorizations signed by the parent, guardian, custodian or court, including releases or authorizations for anesthesia and emergency medical and surgical treatment.

(3) A record of all medical and dental examinations, including findings.

(4) Date of last physical examination prior to placement.

e. School.

(1) Name and address of school attended.

(2) Grade placement.

(3) Current school in which child is enrolled.

(4) Specific educational problems.

(5) Remedial action.

f. Placement agreement, court order, and other releases and authorizations.

(1) An agreement authorizing the facility to accept the child.

(2) An agreement setting forth the terms of payment for care.

(3) Other releases and authorizations applicable to the placement.

(4) All court orders affecting the custody or guardianship of the child.

[**ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.18(232) Discharge. Children in shelter care should be discharged to, preferably, a permanent placement, or, alternatively, a lower level of care in a familylike setting, at the earliest possible time, preferably within 14 days. The facility shall collaborate with referral workers to assess each child's need for ongoing placement, and the reasons for longer stays shall be documented in the child's case file. Children in detention shall be discharged as determined by the court.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.19(232) Approval. The department will issue a Certificate of Approval or a certificate of license annually without cost to any juvenile detention home or juvenile shelter care home which meets the standards. The department may offer consultation to assist homes in meeting the standards.

105.19(1) *Applications.* An application shall be submitted on Form 470-0723, Application for License or Certificate of Approval. The application shall be signed by the operator of the home, chairman of the county board of supervisors, or chairman of the multicounty board of directors and shall indicate the type of home for which the application is made.

a. The withdrawal of an application shall be reported promptly to the department.

b. Each application will be evaluated by the department to ensure that all standards are met.

c. Reports and information shall be furnished to the department as requested.

105.19(2) *Rejection.*

a. Applications will be rejected when the minimum standards set forth in the rules in this chapter are not met.

b. Fraudulent applications will be rejected. A fraudulent application is one which contains false statements knowingly made by the applicant or one in which the applicant knowingly conceals information.

c. Applications will be rejected when the director of the facility has been convicted of a crime indicating an inability to operate a children's facility or care for children.

d. Applications will be rejected for just cause.

105.19(3) *Approval.* Approvals will be given for one year.

105.19(4) *Notification.* Homes should be notified of approval or rejection within 120 days of application unless the applicant requests and is granted an extension by the department. Form 470-0728, Notice of Action, will be used to inform applicants of approval, and a restricted certified letter will be used to inform applicants of rejection.

105.19(5) *Renewals.*

a. Applications for renewal shall be made on forms provided by the department and shall be made at least 30 days, but no more than 90 days, prior to expiration of the approval.

b. Each application for renewal will be evaluated by the department to ensure that standards continue to be met.

c. The application for renewal will be rejected or approved in the same manner as an application.

d. Decisions on renewals should be made within 60 days from the application for renewal. Notification of renewal decisions shall be the same as for new applications.

105.19(6) *Revocations.*

a. Approval shall be revoked by the state director for the following reasons:

(1) When the facility violates laws governing the provision of services or rules contained in this chapter.

(2) When the facility is misusing funds furnished by the department.

(3) When the facility is operating without due regard to the health, sanitation, hygiene, comfort, or well-being of the children in the facility.

(4) When the director has been convicted of a crime indicating an inability to operate a children's facility or care for children.

b. The following may be causes for revocation:

(1) Substantiated child abuse.

(2) When the facility staff has been convicted of a crime indicating an inability to operate a children's facility or care for children.

105.19(7) *Certificate of approval or certificate of license.* Upon approval, county or multicounty homes will be issued a certificate of approval and private juvenile detention and shelter care homes will be issued a certificate of license containing the name of the home, address, capacity, and the date of expiration. Renewals will be shown by a seal bearing the new date of expiration, unless a change requires a new certificate to be issued.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.20(232) Provisional approval.

105.20(1) *Required conditions.* The administrator may issue a provisional license for not more than one year when a facility does not meet the requirements of this chapter and the facility submits a written corrective action plan that is approved by the administrator to bring the facility into compliance with the applicable requirements.

105.20(2) *Written report.* The department or the department's designee will provide a report identifying the reasons for the provisional license and the standards that have not been met.

105.20(3) *Corrective action.* The director of the facility, chairperson of the county board of supervisors, or chairperson of the multicounty board of directors shall provide the department with a written plan of action that is approved by the department for correcting the deficiencies to bring the facility into compliance with the applicable requirements. The plan shall give specific dates by which the corrective action will be completed.

105.20(4) *Completed corrective action.* When the corrective action is completed on or before the date specified, a full approval shall be issued.

105.20(5) *Uncompleted corrective action.* When the corrective action is not completed by the date specified on a provisional approval, the department shall not grant a full approval and has the option of rejecting or extending the provisional approval. An extension of a provisional approval shall not cause the effective period of a provisional approval to exceed 18 months. If the corrective action plan is not completed within 18 months, the approval shall be rejected.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.21(232) Mechanical restraint—juvenile detention only. When a juvenile detention facility uses mechanical restraints as part of its program, the facility shall have written policies regarding their use. These policies shall be approved by the department before use of mechanical restraints. The policies shall be available to clients, parents or guardians, and referral sources at the time of admission. Policies shall also be available to staff. The executive director of the detention home shall sign the commitment contained in Form 470-0703, Evaluation and Recommendation for Approval to Use Mechanical Restraint, before the facility shall be approved to use a mechanical restraint.

105.21(1) *Restrictions on mechanical restraints.*

a. Mechanical restraints shall not inflict physical injury.

b. Each use of mechanical restraint shall be authorized by the executive director of the facility, as discussed in 105.5(4), or other staff designated by the executive director if those staff meet one of the following requirements:

(1) Have a bachelor's degree in social work, psychology or a related behavioral science and one year of supervised experience in a juvenile shelter care, detention or foster group care facility.

(2) Have five years of supervised experience in a juvenile shelter care, detention or foster group care facility.

(3) Have some combination of advanced education in related behavioral sciences and supervised experience in a juvenile shelter care, detention or foster group care facility equal to five years. The facility shall have a written listing of all staff designated and qualified to authorize the use of mechanical restraint.

c. When immediate restraint is necessary to protect the safety of the child, other residents of the facility, staff or others, mechanical restraint may be utilized without prior authorization but in each case a person designated to provide authorization shall be contacted as soon as the child is restrained. The designated person shall visit the resident before determining if continued use of the mechanical restraint is necessary. If not viewed as necessary, the child shall be immediately released from restraint.

d. Except for mechanical restraint of a child by the staff of a juvenile detention facility for the amount of time needed while that child is being transported to a point outside the facility and as necessary when there is a serious risk of the child exiting a vehicle while the vehicle is in motion or otherwise absconding, each authorization of mechanical restraint shall not exceed 1 hour in duration without a visit by and written authorization from a licensed psychologist, psychiatrist or physician .

e. No child shall be kept in mechanical restraint for more than 1 hour in a 12-hour period without a visit by and written authorization from a licensed psychologist, psychiatrist or physician.

f. Anytime that a child is placed in mechanical restraint, a staff person shall be assigned to monitor the child with no duties other than to ensure that the child's physical needs are properly met. The staff person shall remain in continuous auditory and visual contact with the child.

g. Each child shall be released from mechanical restraint as soon as the restraints are no longer needed.

105.21(2) *Documentation.*

a. Each use of mechanical restraints shall be documented in the client's record and shall include at least the following:

(1) The date and time the child was placed in mechanical restraint.
(2) The type of mechanical restraint utilized.
(3) The reason for the restraint.
(4) The signature of the person authorizing the restraint and the time of authorization.
(5) The signature of the person placing the child in restraint.
(6) The signature of the person providing the continuous auditory and visual contact with the child.
(7) The signature of the person releasing the child and the time of release.

b. Each use of mechanical restraint shall be documented in a separate file which is used only for the recording of uses of mechanical restraints and shall contain the name of the child restrained and the information discussed in 105.21(2)*"a."*

c. Each facility authorized to use mechanical restraint shall submit a quarterly report, which shall include all the information required in paragraph 105.21(2)*"b,"* to its licensing manager.

105.21(3) *Continued use of mechanical restraints.* When a child requires mechanical restraint on more than four occasions during any 30-day period, the facility shall hold an immediate emergency meeting within 3 days of the fifth incident and shall have a licensed psychologist or psychiatrist or psychologist employed by a local mental health center present at the staffing to discuss the appropriateness of the child's continued placement at the facility.

105.21(4) *In transporting children.* Seat belts are not considered mechanical restraints. Agency policies should encourage the use of seat belts and comply with Iowa law while transporting children.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—105.22(232) Chemical restraint. Chemical restraint shall not be utilized in juvenile shelter care or detention facilities. Each juvenile shelter care or detention facility shall have written policies which clearly prohibit the use of chemical restraints.

441—105.23(232) Mandatory reporting of child abuse and training.

105.23(1) *Mandatory reporters.* All defined in Iowa Code section 232.69 who, in the scope of professional practice or in their employment responsibilities, examine, attend, counsel, or treat a child and reasonably believe a child has suffered abuse shall make a report in accordance with Iowa Code section 232.69 whenever the provider reasonably believes a child for whom the provider is providing foster care has suffered abuse.

105.23(2) *Required training.* Mandatory reporters shall receive training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69.

105.23(3) *Training documentation.* Each licensee shall develop and maintain a written record for each mandatory reporter in order to document the content and amount of training.

This rule is intended to implement Iowa Code section 232.69.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

These rules are intended to implement Iowa Code section 232.142 as amended by 2011 Iowa Acts, Senate File 482, section 7.

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CHAPTER 106
CERTIFICATION STANDARDS FOR CHILDREN'S RESIDENTIAL FACILITIES

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

PREAMBLE

It is the policy of this state to provide appropriate protection for children who are separated from the direct personal care of their parents, relatives, or guardians. Therefore, the intent of this chapter is to establish certification standards for facilities that meet the definition of "children's residential facility" pursuant to Iowa Code chapter 237C. Iowa Code chapter 237C requires the department to establish standards that shall, at a minimum, address the basic health and educational needs of children; protection of children from mistreatment, abuse, and neglect; background and records checks of persons providing care to children in facilities certified under this chapter; the use of seclusion, restraint, or other restrictive interventions; health; safety; emergency; and the physical premises on which care is provided by a children's residential facility.

Iowa Code chapter 237C specifies that the standards established by the department shall not regulate religious education curricula at children's residential facilities.

These rules cover definitions, application of the standards, the certification process, and provisions to address basic needs; educational programs and services; protection of children from mistreatment, abuse, and neglect; discipline; background and records checks of persons providing care to children in facilities certified under this chapter; the use of seclusion, restraint, or other restrictive interventions; health; safety; emergencies; the physical premises where care is provided by a children's residential facility; sanitation, water, and waste disposal; staffing; and reports and inspections.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.1(237C) Definitions.

"Administrator" means the administrator of that division of the department designated by the director of human services to administer this chapter or the administrator's designee.

"Agency," unless otherwise provided by law, means an individual, corporation, limited liability company, business trust, estate, trust, partnership or association, or any other legal entity which provides care as a children's residential facility.

"Chemical restraint" means the use of chemical agents, including psychotropic drugs, as a form of restraint.

"Child" or *"children"* means an individual or individuals less than 18 years of age.

"Children's residential facility" means a private facility designed to serve children who have been voluntarily placed for reasons other than an exclusively recreational activity outside of their home by a parent or legal guardian and who are not under the custody or authority of the department of human services, juvenile court, or another governmental agency, that provides 24-hour care, including food, lodging, supervision, education, or other care on a full-time basis by a person other than a relative or guardian of the child, but does not include an entity providing any of the following:

1. Care furnished by an individual who receives the child of a personal friend as an occasional and personal guest in the individual's home, free of charge and not as a business.
2. Care furnished by an individual with whom a child has been placed for lawful adoption, unless that adoption is not completed within two years after placement.
3. Child care furnished by a child care facility as defined in Iowa Code section 237A.1.
4. Care furnished in a hospital licensed under Iowa Code chapter 135B or care furnished in a health care facility as defined in Iowa Code section 135C.1.
5. Care furnished by a juvenile detention home or juvenile shelter care home approved under Iowa Code section 232.142.
6. Care furnished by a child foster care facility licensed under Iowa Code chapter 237.
7. Care furnished by an institution listed in Iowa Code section 218.1.
8. Care furnished by a facility licensed under Iowa Code chapter 125.

9. Care furnished by a psychiatric medical institution for children licensed under Iowa Code chapter 135H.

"Control room" means a locked room used for treatment purposes.

"Department" means the Iowa department of human services.

"Mechanical restraint" means restriction of a child's mobility or ability to use the child's hands, arms, or legs by the use of a mechanical device.

"Physical restraint" means direct physical contact required on the part of a staff member to prevent a child from hurting self, others, or property.

"Prone restraint" means a physical restraint in which a child is held face down on the floor.

"Protective locked environment" means the same as defined in Iowa Code section 237.1(17).

"Staff" means any person providing care or services to or on behalf of the facility whether the person is an employee of the facility, an independent contractor or any other person who contracts with the facility, an employee of an independent contractor or any other person who contracts with the facility, or a volunteer.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17; **ARC 0109D**, IAB 3/4/26, effective 5/1/26]

441—106.2(237C) Application of the standards. These rules shall apply to all facilities that meet the definition of "children's residential facility" pursuant to Iowa Code chapter 237C. In the event that a children's residential facility is also subject to licensure, certification, registration, or regulation pursuant to another provision of law, those legal requirements shall take precedence over these rules.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.3(237C) Application for a certificate of approval. A person shall not operate a children's residential facility without a certificate of approval to operate issued by the administrator.

106.3(1) *Right to apply.*

a. Any adult individual or agency may apply for a certificate of approval.

b. Parties wishing to apply for certification as a children's residential facility shall contact the department using the department's website or by contacting the Iowa Department of Human Services, Division of Adult, Children and Family Services, Attn: children's residential facility certification, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

106.3(2) *Application.* An applicant shall complete Form 470-0723, Application for License or Certificate of Approval.

106.3(3) *Withdrawal of an application.* The applicant shall report the withdrawal of an application promptly to the department.

106.3(4) *Evaluation of the application.* Each application will be evaluated by the department to ensure that all standards are met.

a. Before it results in adverse action, a founded abuse report on a director, a sole proprietor involved in the facility's operation, or any facility staff shall be evaluated by the department to determine if the abuse merits prohibition of employment, volunteer work, or certification.

b. The department shall evaluate all founded child abuse on a case-by-case basis. Considerations shall include, but not be limited to:

(1) The applicant's or certified entity's response (e.g., immediate termination of involved staff).

(2) Whether the abuse was an isolated incident or is symptomatic of a broader, systemic problem.

106.3(5) *Reports and information.* The applicant shall furnish requested reports and information relevant to the certification determination to the department.

106.3(6) *Applications for renewal of certificate of approval.*

a. The department or its agent shall send the certificate of approval holder an application for renewal 90 days before the certificate expires. Applications for certificate renewal shall be made on the form specified in subrule 106.3(2).

b. Applications for certificate renewal shall be made at least 30 days but no more than 90 days before the certificate of approval expires. Applications for renewal of a children's residential facility certificate of approval shall be submitted to the address listed in paragraph 106.3(1)*"b."*

106.3(7) *Notification.* The department shall notify a children's residential facility of approval or denial of a certificate within 90 days of the department's receipt of complete application or reapplication information.

106.3(8) *Fire inspection.*

a. Before the administrator issues or reissues a certificate of approval to a children's residential facility, the facility shall comply with standards adopted by the state fire marshal under Iowa Code chapter 100.

b. Each children's residential facility shall procure an annual fire inspection approved by the state fire marshal and shall meet the recommendations thereof.

c. In the case of a conflict between rules and standards adopted pursuant to this chapter and local rules and standards, the more stringent requirement applies.

This rule is intended to implement Iowa Code sections 237C.4 and 237C.6.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.4(237C) Certificate of approval.

106.4(1) A new certificate of approval shall be obtained when the certified location moves or the facility is remodeled.

106.4(2) The certificate of approval shall state on its face the name of the holder of the certificate, the particular premises for which the certificate is issued, and the number of children who may be cared for by the children's residential facility on the premises at one time under the certificate of occupancy issued by the state fire marshal or the state fire marshal's designee. The certificate of approval shall be posted in a conspicuous place in the children's residential facility.

106.4(3) A children's residential facility shall operate only in a building or on premises designated in the certificate of approval.

106.4(4) A new certificate of approval shall be requested when the children's residential facility wishes to be certified for a different number of children.

106.4(5) The department shall issue Form 470-0620, Certificate of Approval, without cost to any children's residential facility that meets the standards. The department may offer consultation to assist applicants in meeting the standards.

106.4(6) Children's residential facilities shall be certified for a term of one year.

This rule is intended to implement Iowa Code sections 237C.6 and 237C.7.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.5(237C) Denial, suspension, or revocation.

106.5(1) The administrator may deny an application for issuance or reissuance of a certificate of approval if:

a. The applicant or certificate holder, as applicable, fails to comply with these rules or knowingly makes a false statement concerning a material fact or conceals a material fact on the application for the issuance or reissuance of a certificate of approval or in a report regarding operation of the children's residential facility submitted to the administrator.

b. The applicant or any person residing in the children's residential facility or any facility staff has a record of founded child abuse unless an evaluation of the founded abuse has been made by the department which concludes that the abuse does not merit prohibition of employment, volunteer work, or certification.

106.5(2) The administrator may suspend a certificate of approval if:

a. The applicant or certificate holder, as applicable, fails to comply with these rules or knowingly makes a false statement concerning a material fact or conceals a material fact on the application for the issuance or reissuance of a certificate of approval or in a report regarding operation of the children's residential facility submitted to the administrator.

b. A children's residential facility's failure to meet the certification requirements poses a danger to the health, safety, or well-being of the children being served.

c. A children's residential facility fails to comply with Iowa Code section 282.34.

106.5(3) All operations of a children's residential facility shall cease during a period of suspension or revocation of a certificate of approval, including during an appeal. A suspension of a certificate of

approval shall not extend beyond six months, and the existence of the condition requiring suspension shall be corrected within six months and documented in the record of the holder of the certificate of approval.

106.5(4) Effective period of suspension. A suspension shall be effective on the date the notice is received by the holder of the certificate of approval and shall remain in effect until one of the following occurs:

a. The department withdraws the suspension due to a change in conditions in the children's residential facility.

b. The court orders the certificate of approval reinstated.

c. The action is reversed by a final decision in accordance with 441—Chapter 7.

d. The certification period expires.

106.5(5) Method and content of notice. The notice of suspension shall be sent by restricted certified mail or personal service and shall include the following:

a. The condition requiring the suspension.

b. The specific law or rule violated.

106.5(6) The administrator may revoke a certificate of approval if:

a. The applicant or certificate holder, as applicable, fails to comply with these rules or knowingly makes a false statement concerning a material fact or conceals a material fact on the application for the issuance or reissuance of a certificate of approval or in a report regarding operation of the children's residential facility submitted to the administrator.

b. The conditions requiring suspension are not corrected within six months.

c. A children's residential facility fails to comply with Iowa Code section 282.34.

106.5(7) Right to appeal suspension or revocation. The holder of the certificate of approval has the right to appeal a suspension or revocation of the certificate of approval, but initiation of an appeal does not alter the suspension or revocation. Notices of adverse actions and the right to appeal shall be given to applicants and certificate of approval holders in accordance with 441—Chapter 7 and rule 441—16.3(17A).

106.5(8) Corrective action. The facility shall furnish the department with a plan of action to correct deficiencies that resulted in the suspension or revocation of a certificate of approval. The plan shall give specific dates upon which the corrective action will be completed.

This rule is intended to implement Iowa Code section 237C.6.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17; **ARC 4973C**, IAB 3/11/20, effective 4/15/20]

441—106.6(237C) Providing for basic needs.

106.6(1) A children's residential facility shall provide the following for children in its care:

a. Adequate shelter.

b. Nourishing food and water.

c. Opportunities for adequate sleep, exercise, cleanliness, and health maintenance.

106.6(2) A children's residential facility shares responsibility for meeting these basic needs with the children's parents, guardians, or other primary caretakers.

106.6(3) A children's residential facility shall have written policies related to:

a. Children's communication with their parents or guardians.

b. Children's ability to receive visitors who have been approved by their parents or guardians.

c. Confidentiality and reasonable privacy for children. The children's residential facility shall afford children and their families privacy and confidentiality unless doing so would jeopardize a child's health or safety.

d. Children's ability to keep personal belongings such as clothing, pictures, and other items.

e. Children's ability to participate in normal community activities.

106.6(4) A children's residential facility shall not impose rules and restrictions that prevent communication with parents, guardians, other family members, or others.

106.6(5) A children's residential facility shall share its written policies related to communication, visitors, personal belongings, and participation in community activities with a child's parents or guardians before a child is admitted to the children's residential facility.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.7(237C) Educational programs and services. A children's residential facility operating under a certificate of approval issued under Iowa Code chapter 237C shall comply with rules adopted by the state board of education pursuant to Iowa Code section 282.34.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.8(237C) Protection from mistreatment, physical abuse, sexual abuse, and neglect.

106.8(1) The state of Iowa prohibits child abuse as defined in Iowa Code chapter 232, criminal assault, and other criminal acts of violence. A children's residential facility shall not use discipline that amounts to child abuse or a criminal act of assault or violence.

106.8(2) A children's residential facility's written policies shall:

a. Prohibit mistreatment, physical abuse, sexual abuse, and neglect of children.

b. Specify reporting and enforcement procedures for the children's residential facility. Alleged violations shall be reported immediately to the director of the facility and appropriate department of human services personnel.

c. Prohibit the use of corporal punishment. The facility's policies shall clearly prohibit staff or the children from utilizing corporal punishment as a method of discipline or correcting children.

d. These policies shall be communicated in writing to all staff of the facility.

This rule is intended to implement Iowa Code section 237C.3.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.9(237C) Discipline.

106.9(1) Generally. The facility shall have written policies, which shall be available to all staff and to the child's family, regarding methods used for control and discipline of children. Agency staff shall be in control of and responsible for discipline at all times. Discipline shall not include the withholding of basic necessities such as food, clothing, or sleep.

106.9(2) Corporal punishment is prohibited. The facility shall have a policy that clearly prohibits staff or the children from utilizing corporal punishment as a method of disciplining or correcting children. This policy is to be communicated in writing to all staff of the facility.

106.9(3) The administration of discipline by a child to another child is prohibited.

106.9(4) Behavior expectations. The facility shall make available to the child and the child's parents or guardian written policies regarding the following areas:

a. The general expectation of behavior, including the facility's rules and practices.

b. The range of reasonable consequences that may be used to deal with inappropriate behavior.

106.9(5) Discipline policies shall be discussed with:

a. Staff, volunteers, or others who perform duties under a subcontract with the children's residential facility; and

b. Parents or guardians before children are admitted to the children's residential facility.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.10(237C) Record checks.

106.10(1) A children's residential facility shall conduct record checks for:

a. Any owner, director, staff member, volunteer, or other person who performs duties under a subcontract with the children's residential facility and who:

(1) Has direct responsibility for children, or

(2) Has access to a child when the child is alone.

b. Anyone living in the children's residential facility who is 14 years of age or older.

106.10(2) The record checks shall be conducted to determine whether the person:

a. Has any founded child abuse reports.

b. Has any founded dependent adult abuse reports.

c. Has any criminal convictions.

d. Has been placed on the sex offender registry.

106.10(3) Every applicant for employment shall submit to the children's residential facility a written, signed and dated statement that discloses:

a. Any substantiated instances of child abuse, neglect, or sexual abuse committed by the person.

b. Any substantiated instances of dependent adult abuse committed by the person.

c. Any convictions of crimes involving the mistreatment or exploitation of a child.

106.10(4) A children's residential facility may request additional information from the central abuse registry or the Iowa department of public safety.

106.10(5) If a record of criminal conviction or founded child abuse or founded dependent adult abuse exists, the children's residential facility shall evaluate the crime or founded child abuse or dependent adult abuse to determine whether or not the crime or founded child abuse or founded dependent adult abuse merits prohibition of employment or any voluntary or subcontracted position. The evaluation shall consider:

a. The nature and seriousness of the crime or founded abuse in relation to the position sought,

b. The time elapsed since the commission of the crime or founded abuse,

c. The circumstances under which the crime or founded abuse was committed,

d. The degree of rehabilitation,

e. The number of crimes or founded abuses committed by the person involved, and

f. The likelihood that the person will commit the crime or founded abuse again.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.11(237C) Seclusion and restraints.

106.11(1) A children's residential facility shall not physically restrain a child unless necessary to prevent the child from hurting self, others, or property. Physical restraint must be conducted in a standing position whenever possible. Prone restraint is prohibited.

a. No staff person shall use any restraint that obstructs the airway of a child.

b. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint.

c. If a staff person physically restrains a child who uses sign language or an augmentative mode of communication as the child's primary mode of communication, the child shall be permitted to have the child's hands free of restraint for brief periods unless the staff person determines that such freedom appears likely to result in harm to the child, others, or property.

d. The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the child's rights and to ensure safety shall be clearly set forth in the child's record by the responsible staff persons.

106.11(2) A children's residential facility shall not put a child into time-out seclusion for more than one hour. A child shall never be secluded in an area that is locked or out of the view of staff, volunteers, or others who perform duties under a subcontract with the children's residential facility.

106.11(3) At no time shall a children's residential facility use a control room, mechanical restraint, or chemical restraint.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.12(237C) Health.

106.12(1) A children's residential facility shall obtain, store, prepare, and serve food and water free from contamination.

106.12(2) A children's residential facility shall have written health policies that describe how the facility will care for a sick child residing there.

106.12(3) A children's residential facility shall have written policies and procedures related to disease control and the use of universal precautions for handling of any bodily excrement or discharge, including blood and breast milk. A children's residential facility shall take precautions to prevent the spread of infectious and communicable disease.

106.12(4) A children's residential facility shall seek immediate medical attention for a child when it is necessary to ensure that the child remains healthy. There shall be 24-hour emergency and routine medical and dental services available and provided when prescribed. Provision of these services shall be documented.

106.12(5) A children's residential facility shall have written policies and procedures to ensure that staff, volunteers, or others who perform duties under a subcontract with the children's residential facility demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease and are certified in the provision of first aid and cardiopulmonary resuscitation.

106.12(6) A children's residential facility shall be required to report any reportable disease to the department of public health.

106.12(7) A children's residential facility shall have written policies on physical examination reports or health status statements for all children in the facility's care.

106.12(8) A children's residential facility shall have written policies and procedures for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications.

106.12(9) A children's residential facility shall ensure that a clearly labeled first-aid kit is available and easily accessible to staff, volunteers, or others who perform duties under a subcontract with the children's residential facility at all times when children are in the facility, in the outdoor play area, and on field trips. The first-aid kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

106.12(10) A children's residential facility shall have written policies on reporting illness or injury to parents or guardians. These policies shall be shared with parents or guardians before a child is admitted to the children's residential facility. A significant change in health status or incidents resulting in a serious injury to or death of a child shall be reported immediately to the parent or guardian.

106.12(11) A children's residential facility shall have written policies on smoking and tobacco use that comply with Iowa state law.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.13(237C) Safety.

106.13(1) A children's residential facility shall provide a sufficient number of staff to ensure safe practices that are based on the ages and needs of the children in care to ensure adequate supervision and child safety. This requirement applies to daytime and overnight hours.

106.13(2) Poison control centers' telephone numbers shall be posted in prominent locations and readily available. All poisonous or caustic drugs or materials shall:

a. Be plainly labeled.

b. Be stored separately from other drugs in a specific, well-illuminated cabinet, closet, or storeroom.

c. Be stored in a manner that prevents accidental or intentional ingestion.

d. Be accessible only to authorized persons.

106.13(3) A children's residential facility shall have written policies regarding fishing ponds, lakes, or any bodies of water located on or near the facility's grounds and accessible to children.

a. All swimming pools shall conform to state and local health and safety regulations.

b. Adult supervision shall be provided at all times when children are near or in the water.

106.13(4) A children's residential facility shall have written policies regarding transportation of a child that ensure compliance with Iowa Code section 321.446 regarding child restraint devices.

a. Drivers of vehicles shall possess a valid driver's license.

b. Drivers shall not operate a vehicle while under the influence of alcohol, illegal drugs, or prescription or nonprescription drugs that could impair the drivers' ability to operate a motor vehicle.

c. All vehicles used for children's residential facility activities shall be maintained in safe operating condition.

d. A children's residential facility shall have proof of current insurance that covers all vehicles and drivers used to transport children.

106.13(5) Animals kept on site shall:

a. Be in good health with no evidence of disease.

b. Be of such disposition as to not pose a safety threat to any person.

c. Be maintained in a clean and sanitary manner.

106.13(6) Weapons and ammunition are prohibited on the premises of a children's residential facility.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.14(237C) Emergencies.

106.14(1) A children's residential facility shall have written emergency plans for responding to evacuations, fires, tornadoes, floods, blizzards, other weather incidents, power failures, bomb threats, chemical spills, earthquakes, or other natural or man-made disasters that could create structural damage to the children's residential facility or pose health or safety hazards.

a. The emergency plans shall include guidelines for responding to situations involving intruders within the children's residential facility and grounds, intoxicated persons, lost or abducted children, and evacuations.

b. Emergency plans shall be coordinated with county emergency planning agencies.

c. Evacuations and how to seek protective shelter shall be practiced periodically.

106.14(2) The emergency plans shall include procedures for annual training regarding the contents and implementation of the plans for staff, volunteers, or others who perform duties under a subcontract with the children's residential facility.

106.14(3) A children's residential facility shall have:

a. Written policies and procedures for medical and dental emergencies.

b. Sufficient information and authorization to meet the medical and dental needs or emergencies of children.

106.14(4) Emergency telephone numbers shall be readily available, including emergency telephone numbers for parents or guardians.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.15(237C) Buildings and physical premises. A children's residential facility shall ensure that the facility and grounds, playground surfaces and other areas, and all related equipment are safe and free from hazards.

106.15(1) A children's residential facility shall comply with requirements established by the fire marshal for the applicable type of occupancy and shall comply with any applicable additional fire safety requirements established by local ordinance, including fire inspections.

106.15(2) A children's residential facility shall be structurally sound. Any new facility or existing facility that is extensively renovated shall be constructed in compliance with applicable requirements of the state of Iowa building code established pursuant to Iowa Code chapter 103A and with any local building code in force at the time of construction.

106.15(3) A children's residential facility located in a building built before 1960 shall conduct a visual assessment for lead hazards that exist in the form of peeling or chipping paint.

a. If the presence of peeling or chipping paint is found, the paint shall be presumed to be lead-based paint unless a certified inspector as defined in department of public health rules at 641—Chapter 70 determines that the paint is not lead-based.

b. In the absence of the determination that peeling or chipping paint is not lead-based, a children's residential facility shall use safe work methods as defined by the state department of public health to eliminate human exposure or likely exposure to lead-based paint hazards.

106.15(4) Living areas.

a. All living areas shall:

(1) Have screens on windows used for ventilation.

(2) Be maintained in clean, sanitary conditions, free from vermin, rodents, dampness, noxious gases and objectionable odors.

(3) Be in safe repair.

(4) Provide for adequate lighting when natural sunlight is inadequate.

(5) Have heating and storage areas separated from sleeping or play areas.

(6) Have walls and ceiling surfaced with materials that are asbestos-free.

b. All sleeping rooms shall:

(1) Provide a minimum of 60 square feet per child for multiple occupancy.

(2) Provide a minimum of 80 square feet per child for single occupancy.

(3) Not sleep more than four children per room.

(4) Be of finished construction.

c. Rooms aboveground shall:

(1) Have a ceiling height of at least 7 feet, 6 inches.

(2) Have a window area of at least 8 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

d. Rooms belowground shall:

(1) Have a ceiling height of at least 6 feet, 8 inches.

(2) Have a window area of at least 2 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

(3) Have floor and walls constructed of concrete or other materials with an impervious finish and free from groundwater leakage.

106.15(5) Bedrooms.

a. Each child in care shall have a solidly constructed bed.

b. Sheets, pillowcases, and blankets shall be provided for each child and shall be kept clean and in good repair.

c. Each child in care shall have adequate storage space for private use and a designated space for hanging clothing in proximity to the bedroom occupied by the child.

d. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

106.15(6) Heating.

a. The heating unit shall be located and operated to maintain the temperature in the living quarters at a minimum of 65 degrees Fahrenheit during the day and 55 degrees Fahrenheit during the night. Variances may be made in case of health problems. Temperature is measured at 24 inches above the floor in the middle of the room.

b. All space heaters and water heaters involving the combustion of fuel, such as gas, oil or similar fuel, shall be vented to the outside atmosphere.

c. Neither rubber nor plastic tubing shall be used as supply lines for gas heaters.

d. The heating or cooling plant shall be checked at least annually and kept in safe working condition at all times.

These rules are intended to implement Iowa Code section 237C.3.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.16(237C) Sanitation, water, and waste disposal. In the case of a conflict between rules and standards adopted pursuant to this chapter and local rules and standards, the more stringent requirement applies.

106.16(1) *Bathroom facilities.*

a. Bathrooms shall have an adequate supply of hot and cold running water.

b. Each bathroom shall be properly equipped with toilet tissue, towels, soap, and other items required for personal hygiene unless children are individually given these items. Paper towels, when used, and toilet tissue shall be in dispensers.

c. Toilets and baths or showers shall provide for individual privacy.

d. There shall be a shower or tub for each ten children or portion thereof.

e. Tubs and showers shall have slip-proof surfaces.

f. At least one toilet and one lavatory shall be provided for each six children or portion thereof.

g. Toilet facilities shall be provided with natural or artificial ventilation capable of removing odors and moisture.

h. Toilet facilities adjacent to a food preparation area shall be separated completely by an enclosed solid door.

i. All toilet facilities shall be kept clean.

j. When more than one stool is used in one bathroom, partitions providing privacy shall be used.

k. Toilets, wash basins, and other plumbing or sanitary facilities shall be maintained in good operating condition.

106.16(2) *Food preparation and storage.*

a. Cracked dishes and utensils shall not be used in the preparation, serving, or storage of food.

b. Storage areas for perishable foods shall be kept at 45 degrees Fahrenheit or below.

c. Storage areas for frozen foods shall be kept at 0 degrees Fahrenheit or below.

d. Food that is to be served hot shall be maintained at 140 degrees Fahrenheit or above.

e. Food that is to be served cold shall be maintained at 45 degrees Fahrenheit or below.

f. The kitchen and food storage areas shall be kept clean and neat. Foods shall not be stored on the floor.

g. The floor and walls shall be of smooth construction and in good repair.

106.16(3) *Personnel handling food.* Personnel who handle food shall:

a. Be free of infection.

b. Be clean and neatly groomed.

c. Wear clean clothes.

d. Not use tobacco in any form while preparing or serving food.

106.16(4) *Dishwashing facilities.*

a. Manual dishwashing will be allowed in facilities that normally serve 15 or fewer people at one meal.

b. Commercial dishwashers shall be used in facilities serving more than 15 people at one meal and shall meet the following criteria:

(1) When chemicals are added for sanitation purposes, they shall be automatically dispensed.

(2) Machines using hot water for sanitizing must maintain wash water at a temperature of at least 150 degrees Fahrenheit and rinse water at a temperature of at least 180 degrees Fahrenheit or a single temperature machine at 165 degrees Fahrenheit for both wash and rinse.

(3) All machines shall be thoroughly cleaned and sanitized at least once each day or more often if necessary to maintain satisfactory operating condition.

c. Soiled and clean dish table areas shall be of adequate size to accommodate the dishes for one meal.

d. All handheld food preparation and serving equipment shall be cleaned and sanitized following each meal. Dispensers, urns, and similar equipment shall be cleaned and sanitized daily.

106.16(5) *Foods not prepared at site of serving.*

a. The place where food is prepared for off-site serving shall conform to all requirements for on-site food preparation.

b. Food shall be transported in covered containers or completely wrapped or packaged so as to be protected from contamination.

c. During transportation, and until served, hot foods shall be maintained at 140 degrees Fahrenheit or above and cold food shall be maintained at 45 degrees Fahrenheit or below.

106.16(6) *Milk supply.* When fluid milk is used, it shall be pasteurized Grade A.

106.16(7) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system, as regulated by the department of natural resources.

106.16(8) *Private water supplies.* Any facility that serves at least 25 people for at least 60 days during the year and is supplied by its own well meets the definition of a public water supply and must be regulated by the department of natural resources.

a. Each privately operated water supply shall be maintained and operated in a manner that ensures safe drinking water. Each water supply used as part of a facility shall be annually inspected and evaluated for deficiencies that may allow contaminants access to the well interior. Items such as open or loose well caps, missing or defective well vents, poor drainage around the wells, and the nearby storage of potential contaminants shall be evaluated. All deficiencies shall be corrected within 30 days of discovery by a well contractor certified by the state.

b. Evaluation and water testing. As part of the inspection and evaluation, water samples shall be collected and submitted by the local health sanitarian or a well contractor certified by the state to the state hygienic laboratory or other laboratory certified for drinking water analysis by the department of natural resources. The minimum yearly water analysis shall include coliform bacteria and nitrate (NO_3^-) content. Total arsenic testing shall be performed once every three years. The water shall be deemed safe when there are no detectible coliform bacteria, when nitrate levels are less than 10 mg/L as nitrogen, and when total arsenic levels are 10 µg/L or less. A copy of the laboratory analysis report shall be provided to the department within 72 hours of receipt by the water supply.

c. Multiple wells supplying water. When the water supply obtains water from more than one well, each well connected to the water distribution system shall meet all of the requirements of these rules.

d. Deficiencies. When no apparent deficiencies exist with the well or its operations and the water supply is proven safe by meeting the minimum sampling and analysis requirements, water safety requirements have been met. Wells with deficiencies that result in unsafe water analysis require corrective actions through the use of a well contractor certified by the state.

e. When water is proven unsafe. When the water supply is proven unsafe by sampling and analysis, the facility shall immediately provide a known source of safe drinking water for all water users and hang notification at each point of water use disclosing the water is not safe to consume. In addition, the facility shall provide a written statement to the department disclosing the unsafe result and detail a plan on how the water supply deficiencies will be corrected and the supply brought back into a safe and maintained condition. The statement shall be submitted to the department within 10 days of the laboratory notice. All corrective work shall be performed and the water supply sampled and analyzed again within 45 days from any water test analysis report that indicates the water supply is unsafe for drinking water uses.

f. Water obtained from another source through hauling and storage must meet the requirements of the department of natural resources.

106.16(9) *Heating or storage of hot water.* Each tank used for the heating or storage of hot water shall be provided with a pressure and temperature relief valve.

106.16(10) *Sewage treatment.*

a. A children's residential facility shall be connected to a public sewer system where available.

b. Private disposal systems shall be designed, constructed, and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

106.16(11) *Garbage storage and disposal.*

a. A sufficient number of garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be insect-, rodent-, and leakproof and shall be maintained in a sanitary condition.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.17(237C) Staffing.

106.17(1) Children's residential facility staff shall be 21 years of age or older with appropriate training and experience related to job duties.

106.17(2) A children's residential facility shall have written policies and procedures regarding staff supervision, development, training requirements, and orientation to children's residential facility policies and practices.

106.17(3) A children's residential facility shall provide a sufficient number of staff to ensure proper supervision and child safety at all times and at all activities conducted by a children's residential facility off its premises.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.18(237C) Reports and inspections.

106.18(1) The administrator may require submission of reports by a certificate of approval holder and shall cause at least one annual unannounced inspection of a children's residential facility to assess compliance with applicable requirements and standards.

106.18(2) The inspections shall be conducted by the department of inspections and appeals in addition to initial, renewal, and other inspections that result from complaints or self-reported incidents.

106.18(3) The department of inspections and appeals and the department of human services may examine records of a children's residential facility and may inquire into matters concerning the children's residential facility and its employees, volunteers, and subcontractors relating to requirements and standards for children's residential facilities under this chapter.

[**ARC 3007C**, IAB 3/29/17, effective 5/3/17]

441—106.19(232) Mandatory reporting of child abuse.

106.19(1) *Mandatory reporters.* Any employee, operator, owner, or other person who performs duties for a children's residential facility shall make a report, in accordance with Iowa Code section 232.69, whenever that person reasonably believes a child for whom the person is providing care has suffered abuse.

106.19(2) *Required training.* Staff shall receive training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69.

106.19(3) *Training documentation.* The certified children's residential facility shall develop and maintain a written record for each employee, operator, owner, or other person who performs duties for the children's residential facility in order to document the content and amount of training.

This rule is intended to implement Iowa Code section 232.69.

[**ARC 4113C**, IAB 11/7/18, effective 1/1/19]

These rules are intended to implement Iowa Code chapter 237C.

[Filed ARC 8009B (Notice ARC 7769B, IAB 5/20/09), IAB 7/29/09, effective 9/2/09]
[Filed ARC 3007C (Notice ARC 2918C, IAB 2/1/17), IAB 3/29/17, effective 5/3/17]
[Filed ARC 4113C (Notice ARC 3971C, IAB 8/29/18), IAB 11/7/18, effective 1/1/19]
[Filed ARC 4973C (Notice ARC 4675C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]
[Filed ARC 0109D (Notice ARC 9845C, IAB 12/24/25), IAB 3/4/26, effective 5/1/26]

CHAPTER 107
CERTIFICATION OF ADOPTION INVESTIGATORS
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 12/1/31

441—107.1(600,234) Definitions.

"Adoption work experience" means supervised employment in adoption services, which includes direct provision of adoption services, developing adoption policies, conducting training related to adoption services, oversight and review of adoption documents and activities, and direct supervision of adoption workers. Only the percentage of time related to provision of adoption services shall be considered as adoption work experience when job duties involve activities other than adoption services.

"Certified adoption investigator" means a person authorized by the department to provide background reports on birth parents, adoption preplacement investigations, postplacement supervision, and reports to the court within the state of Iowa.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.2(600,234) Application.

107.2(1) *Application form.* Application for certification as an adoption investigator shall be made on a form obtained from the department.

107.2(2) *Employees of licensed child-placing agencies and the department.* Persons employed as social workers in licensed child-placing agencies who meet the requirements for certification in rule 441—107.3(600,234) are eligible to apply for certification as adoption investigators unless the agency employing them objects in writing.

a. The applicant shall furnish a letter of approval from the agency as part of the certification process.

b. Persons employed as social workers for the department who meet the requirements for certification in rule 441—107.3(600,234) are eligible to apply for certification as adoption investigators for services provided outside of their current job duties unless their current job duties include any of the following:

(1) Any of the activities described in rule 441—107.7(600,234).

(2) Immediate supervision of employees engaged in activities described in rule 441—107.7(600,234).

(3) Certification of adoption investigators.

(4) Placement of children for adoption.

(5) Development of adoption policies used in administration of the adoption program.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.3(600,234) Requirements for certification. Persons with academic qualifications and adoption work experience may be certified by the department to provide adoption preplacement investigations, postplacement supervision, and reports to the court.

107.3(1) *Office location.* The applicant shall retain an office in Iowa where all Iowa adoption reports and records of fees are maintained and are available for inspection.

107.3(2) *Education and experience.*

a. If the applicant was initially certified as an adoption investigator before October 1, 1991, the applicant shall have one of the following combinations of education and experience:

(1) Graduation from an accredited four-year college or university and adoption work experience equivalent to a total of three years of full-time experience.

(2) A bachelor's degree in social work from an accredited four-year college or university in a program accredited by the council on social work education and adoption work experience equivalent to a total of two years of full-time experience.

(3) A master's degree in social work from an accredited college or university in a program accredited by the council on social work education and adoption work experience equivalent to a total of one year of full-time experience.

b. If the applicant is initially certified as an adoption investigator on or after October 1, 1991, the applicant shall have one of the following combinations of education and experience:

(1) Graduation from an accredited four-year college or university with a bachelor's degree in social work, psychology, counseling, family therapy, family living, or other family-oriented degree and postgraduation adoption work experience equivalent to a total of three years of full-time experience.

(2) Graduate education in a master's program in social work, psychology, counseling, family therapy, family living, or other family-oriented program from an accredited four-year college or university may be substituted for required adoption work experience on the basis of 30 semester hours for one year of full-time experience, for up to two full years of the required three years of adoption work experience.

(3) A master's degree in social work, psychology, counseling, family therapy, family living, or other family-oriented degree from an accredited college or university and postgraduation adoption work experience equivalent to a total of one year of full-time experience.

107.3(3) *Verification of qualifications.*

a. The applicant shall provide a certified transcript of college credits; and

b. The applicant shall provide a record of all adoption work experience, including dates and location; and

c. The applicant shall provide the name(s) of employer(s) and supervisor(s) to enable the department to verify the applicant's adoption work experience; and

d. The applicant shall give names of at least two additional persons as character references who will be contacted by the certifier.

107.3(4) *Statement of activities and duties.* Prior to certification, the applicant shall prepare a written statement identifying the proposed activities, duties and fees of the applicant as a certified adoption investigator.

a. The statement shall indicate that the services described in rule 441—107.7(600,234) are being provided by the individual investigator, not a child-placing agency, and are not provided in the course of the individual investigator's employment with a child-placing agency or the department.

b. The activities and duties identified in the statement cannot exceed the scope of an investigator's services as defined in rule 441—107.7(600,234).

c. The statement shall include the fee schedule to be used in the determination of a charge for investigative services.

d. A copy of the statement shall be provided to the department to be maintained as a public record.

e. Upon request, this statement shall be provided by the investigator to persons requesting services from the investigator.

107.3(5) *Record checks.* The department of inspections, appeals, and licensing shall submit record checks for each new applicant and those applying for recertification to determine whether they have any founded child abuse reports, dependent adult abuse reports or convictions or have been placed on the sex offender registry.

a. The department of inspections, appeals, and licensing shall use the Request for Child Abuse and Dependent Adult Abuse Information form, and the Iowa Division of Criminal Investigation Criminal History Record Check Request form, for this purpose. The department will not certify the applicant with a record of founded child abuse, dependent adult abuse, a criminal conviction, or placement on the sex offender registry as an adoption investigator unless evaluation of the founded abuse or crime indicates approval for certification.

b. The applicant shall complete and return a Record Check Evaluation form, within ten calendar days of the date on the form, to be used by the department to assist in the evaluation. Failure of the applicant to complete and return the Record Check Evaluation form within the specified time frame will result in denial of certification.

c. The department will evaluate the nature and seriousness of the founded abuse or crimes, the time elapsed since the commission of the founded abuse or crimes, the circumstances under which the founded abuse or crime was committed, the degree of rehabilitation, the likelihood that the person will commit the abuse or crime again, and the number of founded abuses or crimes committed by the applicant. The

department will issue a notice of decision to the applicant of the results of the evaluation. The department will issue the notice of decision even in cases when the applicant fails to complete the evaluation form.

d. Investigators applying for recertification are subject to the same record checks as new applicants. The department will evaluate only abuses, convictions of crimes, and placement on the sex offender registry since the last record check using the same process.

107.3(6) *Certification actions for nonpayment of child support.* The department will revoke or deny the issuance or renewal of a certification of an adoption investigator upon the receipt of a certificate of noncompliance from child support services. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter apply.

a. The notice required by Iowa Code section 252J.8 will be provided to the applicant in writing.

b. The effective date of the revocation or denial of the certification as specified in the notice required by Iowa Code section 252J.8 will be 60 days following service of the notice upon the applicant or certified investigator.

c. The department is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or certified investigator.

d. Applicants and certified investigators shall keep the department informed of all court actions, and all child support services actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in these actions, and withdrawals of certificates of noncompliance by child support services.

e. An applicant or certified investigator may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

(1) The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

(2) For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a certification, the department will count the number of days before the action was filed and the number of days after the action was disposed of by the court.

f. The department will notify the applicant or certified investigator in writing within ten days of the effective date of the revocation of certification or the denial of the issuance or renewal of a certificate of adoption investigator and will similarly notify the applicant or certified investigator when the certificate is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

g. Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue, but may request a court hearing pursuant to Iowa Code section 252J.9.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.4(600,234) Granting, denial, or revocation of certification.

107.4(1) *Granting of certification.* When all of the requirements of this chapter are met, certification will be granted.

107.4(2) *Denial or revocation of certification.*

a. Certification or recertification will be denied or revoked when one or more of the following conditions exist:

(1) The applicant does not comply with the requirements listed in subrules 107.3(1), 107.3(2), and 107.3(4) and rules 441—107.9(600,234) and 441—107.10(600,234).

(2) The applicant does not provide information required in subrule 107.3(3).

(3) The applicant has willfully or knowingly misrepresented information regarding qualifications for certification.

(4) When information about the certified investigator is received and verified by the department of inspections, appeals, and licensing, such as but not limited to failure to carry out the activities and duties as stated in this chapter, charging fees in excess of those specified in subrule 107.7(5) and breaches of confidentiality, and the effect of the investigator's actions would be detrimental to any of the parties to the adoption. Complaints involving the reasonable exercise of professional judgment in the denial or approval of a preplacement investigation are not grounds for decertification.

(5) The investigator, after being warned in writing by the licensor, provided incomplete or inadequate information or inaccurate information in required reports as described in rule 441—107.7(600,234).

(6) The applicant has a founded child abuse, dependent adult abuse or criminal record conviction unless an evaluation of the founded abuse or criminal conviction is conducted by the department of inspections, appeals, and licensing that concludes that the abuse or crime does not merit prohibition of certification.

(7) The investigator aids or participates in an illegal placement or violates the statutes of Iowa Code chapter 600.

b. If an applicant is denied certification or recertification based on an inability to meet the requirements, the applicant may reapply when the requirements for certification have been met.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.5(600,234) Certificate.

107.5(1) *Contents.* The State of Iowa Certificate of Adoption Investigator form will contain the name of the investigator and the expiration date of the certificate and be signed by a person designated by the director of the department.

107.5(2) *Time limit.* The investigator will be certified for two years. Certification will expire at the end of two years unless the investigator has made timely application for recertification. No provisional certificates will be issued.

107.5(3) *Records of certifications.*

a. The department will keep records of certifications, including the application and verifications.

b. The department will keep a list of certified adoption investigators by districts and will update the list at least semiannually. Lists of certified adoption investigators will be made available on the department's website.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.6(600,234) Renewal of certification.

107.6(1) *Request for renewal.* To be recertified, the person shall submit a new Application for Certification of Adoption Investigator form at least 30 days before the expiration of the certificate. If no application is submitted, the certification will expire.

107.6(2) *Evaluation of investigator.* Upon receipt of the request for recertification, the department investigators' records shall be reviewed and evaluated by the licensor to determine whether the requirements of these rules have been met.

a. This evaluation shall include the review of 20 percent or no fewer than four of the adoption records opened since the last review for certification and the fees assessed to clients. Reports of investigations will be available to the licensor during the review for recertification, or at any other time upon request by the licensor.

b. When deficiencies are noted at the time of review, the investigator shall be given up to 30 days to meet the standards set forth in 441—Chapter 107.

c. The deficiencies shall be noted in writing and the investigator shall sign a statement that includes agreement to the following:

(1) The deficiencies noted by the licensor, including the areas of 441—Chapter 107 that are not met.

(2) A plan for correcting the deficiencies.

(3) The date by which the deficiencies will be corrected.

d. When the deficiencies are corrected within the time frame granted, the certificate will be renewed. Deficiencies not corrected within the allowed time frame are grounds for revocation of the investigator's certificate.

107.6(3) *Notification.* The department will notify the investigator of the decision regarding the initial application, and any applications for recertification, within 60 days of receipt of the application. When the request for recertification is not received prior to the date of expiration, the department will notify the investigator that the certification has expired.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.7(600,234) Investigative services.

107.7(1) *Preplacement investigations.* When a certified adoption investigator provides a preplacement investigation of a prospective adoptive family, the investigation shall meet the requirements of Iowa Code section 600.8(1)*"a."*

a. The preplacement investigation shall include at a minimum two contacts, one face-to-face interview with the applicants and each member of the household and at least one home visit.

b. The certified adoption investigator shall have on file a written assessment of the family that shall be used to approve or deny a prospective adoptive family. The written home study assessment shall include the date the home study was completed, shall be signed by the investigator and the signature notarized. The assessment shall include the following:

(1) Motivation for adoption and whether the family has biological, adopted, or foster children;

(2) Family and extended family's attitude toward accepting an adopted child, and plans for discussing adoption with the child;

(3) The attitude toward adoption of other people involved with the family in a significant way;

(4) Emotional maturity; marital history, including verification of marriages and divorces; assessment of marital relationship; and compatibility of the adoptive parents;

(5) Ability to cope with problems, stress, frustrations, crises, separation, and loss;

(6) Medical, mental, or emotional conditions that would affect the applicant's ability to parent a child;

(7) Ability to provide for the child's physical and emotional needs and to respect the child's cultural and religious identity;

(8) Description of biological children and previously adopted children, if any, including their attitudes toward adoption, relationships with others, and school performance;

(9) Capacity to give and receive affection;

(10) Statements from at least three references provided by the family and other unsolicited references that the investigator may wish to contact;

(11) Attitudes of the adoptive applicants toward the birth parent(s) and the reason(s) the child is available for adoption;

(12) Income information, including the family's ability to financially provide for a child;

(13) Disciplinary practices that will be used;

(14) History of abuse involving family members, including how the abuse was addressed and how that history impacts the applicant's ability to be an adoptive parent;

(15) Assessment of, commitment to, and capacity to maintain other significant relationships;

(16) Substance use or abuse by members of the household, treatment history and current status of treatment;

(17) Recommendations for the number, age, sex, characteristics, and unique needs of children best served by this family; and

(18) The family's ability to anticipate and understand the unique needs of an adopted child as the child becomes older and how the family will manage those needs.

c. Record checks. The certified adoption investigator shall perform record checks for each applicant and for the other persons living in the home of the applicant as follows:

(1) The records of the applicants shall be checked:

1. On the Iowa central abuse registry using the Request for Child Abuse and Dependent Adult Abuse Information form;

2. By the Iowa division of criminal investigation, using the Criminal History Record Check form;

3. On the Iowa sex offender registry;

4. On the child abuse and dependent adult abuse registry of any state where the applicant has lived during the five years prior to the issuance of the investigative report; and

5. For a national criminal history through fingerprinting or another biometric identification-based process accepted by the federal government.

(2) The records of persons aged 14 or older living in the home of the applicant shall be checked:

1. On the Iowa central abuse registry using the Request for Child Abuse and Dependent Adult Abuse Information form;

2. By the Iowa division of criminal investigation, using the Criminal History Record Check form; and

3. On the Iowa sex offender registry.

(3) Out-of-state child abuse checks, dependent adult abuse checks and national criminal history checks may be completed on any adult in the home of the applicant if the certified adoption investigator has reason to do so.

(4) The person making the investigation shall not approve a prospective applicant and cannot perform an evaluation if the applicant or any other adult living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."*

(5) The person making the investigation shall not approve a prospective applicant and cannot perform an evaluation if the applicant or any other adult living in the home of the applicant has committed a crime in a state other than Iowa that would be a forcible felony if the crime would have been committed in Iowa as set forth in Iowa Code section 600.8(2)*"b."*

d. Evaluation of record. If there is a record of founded child abuse, dependent adult abuse or a criminal conviction for the applicant or any other adult living in the home of the applicant, the applicant shall not be approved to adopt, unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

(1) The evaluation shall consider the nature and seriousness of the founded child abuse, dependent adult abuse or crime in relation to adoption, the time elapsed since the commission of the founded abuse or crime, the circumstances under which the abuse or crime was committed, the degree of rehabilitation, the likelihood that the person will commit the abuse or crime again, and the number of abuses or crimes committed by the person.

(2) The person with the founded child abuse, dependent adult abuse or criminal conviction report shall complete and return the Record Check Evaluation form within ten calendar days of the date on the form to be used to assist in the evaluation. Failure of the person to complete and return the form within the specified time frame may result in a written denial of approval for adoption.

(3) If the applicant, or any other adult living in the home of the applicant, has been convicted of a simple misdemeanor or a serious misdemeanor that occurred five or more years prior to application, the evaluation and decision may be made by a certified adoption investigator. The certified adoption investigator shall notify the applicant of the results of the evaluation in writing. The notice shall contain information on appeal rights.

(4) If the applicant, or any other person living in the home of the applicant, has a founded child or dependent adult abuse report, has been convicted of an aggravated misdemeanor or felony at any time, or has been convicted of a simple or serious misdemeanor that occurred within five years prior to application, a certified adoption investigator shall initially conduct the evaluation.

1. If the certified adoption investigator determines that the abuse or crime does warrant prohibition of approval, the certified adoption investigator shall notify the applicant of the results of the evaluation in writing.

2. If the certified adoption investigator determines that the applicant should be approved despite the abuse or criminal conviction, the certified adoption investigator shall provide copies of the child abuse report, dependent adult abuse report or criminal history record and the Record Check Evaluation form to the department. Within 30 days, the department will determine whether the abuse or crime merits prohibition of approval and will notify the certified adoption investigator in writing of that decision. The certified adoption investigator will notify the applicant of the department's written decision regarding the evaluation of an abuse or crime.

e. Decision. The certified adoption investigator shall notify the applicant in writing no later than 30 days after completion of the home study of the investigator's decision regarding approval for placement of a child.

(1) If the applicant is denied, the certified adoption investigator shall state the reasons for denial in the written decision.

(2) The certified adoption investigator shall date, sign and notarize the adoptive home study.

(3) The certified adoption investigator shall provide a copy of the home study to the family at the time the written decision is sent.

(4) A home study shall be valid for up to two years from the date signed by the certified adoption investigator.

f. Denial. The certified adoption investigator shall deny approval of an adoption application when:

(1) The applicant or any other person living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."*

(2) The standards set forth in these rules are not met and cannot be corrected.

(3) The applicant or any person residing in the home has been convicted of a crime unless an evaluation of the crime has been made by the department that concludes that the crime does not merit prohibition of approval of an adoption application.

(4) The applicant or any person residing in the home has a record of founded child abuse or dependent adult abuse unless an evaluation of the founded child abuse or dependent adult abuse has been made by the department that concluded that the founded child abuse or dependent adult abuse does not merit prohibition of approval of an adoption application.

(5) The applicant has knowingly made false statements or has knowingly concealed information that is material to the investigation.

g. Updates. An update to the home study shall be completed no later than 24 months from the previous home study or previous home study update in order for the home study to remain valid. The home study update shall consist of completion of the following:

(1) The child abuse, dependent adult abuse and criminal history record checks, except for national criminal history checks, shall be repeated. If there are new founded abuses or convictions of crimes that were not evaluated in the previous home study, they shall be evaluated using the process set forth in paragraph 107.7(1)*"d."*

(2) One face-to-face visit shall be conducted with the approved family annually.

(3) The information in the approved home study shall be reviewed.

(4) An updated report of the adoptive home study shall be written, dated, signed and notarized and a copy provided to the applicant.

h. Annual visits to the adoptive home. The certified adoption investigator shall complete a minimum of one visit each year in the homes of families approved to adopt by the investigator.

(1) The visit shall include, at a minimum, an assessment of the following areas:

1. Home environment.
2. Persons present at the time of the visit.
3. Changes in the home or household members, or other areas addressed in the home study.

(2) When a person aged 14 or older moves into the home, the investigator shall perform checks on the Iowa central child and dependent adult abuse registry, by the division of criminal investigation, and on the sex offender registry. The record check evaluation process shall be completed if the person has a criminal conviction, founded child abuse report, founded dependent adult abuse report or is on the sex offender registry.

(3) The findings from the visit shall be documented and maintained in the file.

107.7(2) *Background information investigation.* When a certified adoption investigator is requested to complete a background information investigation on the child to be adopted, the investigation shall include a complete medical, mental health and criminal history of the family and developmental history of the child to be adopted.

a. A personal interview with each parent of the child is mandatory unless a parent's identity or whereabouts is unknown.

b. If a parent's identity or whereabouts is unknown, as much information as possible shall be obtained from the other parent or other sources if available.

c. A copy of the background information shall be provided to prospective adoptive families before placement of the child.

107.7(3) *Postplacement supervision.* Postplacement reports shall be written after each postplacement visit, and copies shall be kept in the permanent family file retained by the investigator.

a. Postplacement supervision shall address the unique needs of the child, including but not limited to the following areas:

(1) Integration and interaction of the child with the family.

(2) Changes in the family functioning that may be due to the child's placement.

(3) Social and emotional adjustment of the child.

(4) Child's growth and development since placement with the adoptive family.

(5) Changes and adjustments that have been made in the family since the child's placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

(8) School adjustment of a child who is attending a school.

(9) The behavioral needs of the child.

(10) The psychological and mental health needs of the child.

(11) Services and supports that will assist the family in the future.

b. Postplacement visits shall be completed at a minimum as follows:

(1) One no later than 30 days after placement.

(2) One no later than 90 days after placement.

(3) A final visit prior to requesting a consent to adopt, no later than 180 days after placement.

(4) Postplacement visits shall be completed as often as necessary if the adoptive family is experiencing problems, and the visits may extend to finalization or beyond 180 days if the department or certified adoption investigator believes additional time is needed.

c. The certified adoption investigator shall prepare a written report based on observations made during each home visit. Each report shall address the specific needs of the child and the family's ability to meet those needs. The reports shall be used by the certified adoption investigator in making a written recommendation to the court regarding finalization of the adoption.

107.7(4) *Reports of investigations.* The certified adoption investigator is authorized to provide reports to the courts concerning the above investigations and reports to the guardian or custodian of the child and the attorney for the adoptive family.

107.7(5) *Fees for services.* Certified adoption investigators may charge a fee for the services described in subrules 107.7(1), 107.7(2), and 107.7(3). The department will review the amount of fees for services charged to families at the time that the investigator's records are reviewed for recertification. Information shall also be retained regarding fees charged to a family by another party and collected by the investigator.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.8(600,234) International adoptions postplacement report.

107.8(1) For an adoption based on a decree issued by another state's jurisdiction within the United States, the certified adoption investigator shall conduct a postplacement investigation and issue a postplacement report as required in 441—subrule 108.9(5).

107.8(2) For an adoption based on a decree issued by a jurisdiction outside the United States, a certified adoption investigator shall conduct a postplacement investigation that consists of a minimum of three face-to-face visits with the minor person and the adoptive parents during the first year after placement, with the first such visit to be conducted within 60 days of the placement of the minor person in the adoptive home. Additional visits may be conducted if required by the jurisdiction that issued the decree.

107.8(3) The postplacement investigation and report under this rule shall include documentation that any unique needs of the minor person are being met appropriately through the placement.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.9(600,234) Retention of adoption records. The adoption investigator shall maintain a record of each family or child when one or more of the required reports have been completed. The record shall contain copies of all completed reports and a statement of fees charged by the investigator.

107.9(1) *Access to records.* The provisions regarding sealing of and access to adoption records in Iowa Code section 600.16 shall be followed, except that access under subrule 107.9(3) for recertification is permitted.

107.9(2) *Disposition of records.* Upon revocation, denial of renewal, or expiration of certification, all sealed records held by investigators shall be forwarded to the department.

107.9(3) *Access for recertification.* Authorized representatives of the department shall have access to all records of reports completed within a two-year period prior to recertification for purposes of recertification.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.10(600,234) Reporting of violations. All violations or suspected violations under Iowa Code chapter 600 or 600A that come to the attention of the investigator shall be reported in writing to the district court having jurisdiction of the matter and to the department. The investigator shall provide copies of these written reports to the district court having jurisdiction of the matter and to the department.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

441—107.11(600,234) Appeals. Certified investigators or applicants may appeal decisions of the department according to rules in 441—Chapter 2506.

[**ARC 0669D**, IAB 10/14/26, effective 12/1/26]

These rules are intended to implement Iowa Code chapters 600 and 234.

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CHAPTER 108
LICENSING AND REGULATION OF CHILD-PLACING AGENCIES

[Prior to 7/1/83, Social Services [770] Ch 108]
[Prior to 2/11/87, Human Services [498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

PREAMBLE

This chapter establishes licensing procedures for all child-placing agencies authorized by Iowa Code chapter 238. Included in this chapter are rules relating to: the licensing process; administration and organization; foster care services; adoption services; and supervised apartment living services.

441—108.1(238) Definitions.

"Administrator" means the person who is designated to have day-to-day responsibility for the administration of a child-placing agency, and who ensures that the mission of the agency and laws relating to the welfare and protection of children are carried out.

"Adoption work experience" means supervised employment in adoption services, which includes direct provision of adoption services, development of adoption policies, provision of training related to adoption services, oversight and review of adoption documents and activities, and direct supervision of adoption workers. Only the percent of time related to provision of adoption services shall be considered as adoption work experience when job duties involve activities other than adoption services.

"Adoptive applicant" means the person who has requested approval for placement of a child for adoption from a licensed child-placing agency.

"Adoptive family" means an approved person or persons who have a child placed in their home for the purpose of adoption and are being supervised by the agency or who have a child in their home who has been legally adopted and is entitled to the same benefits as a child born to the parents.

"Approved living arrangement" means that the living situation shall be located so as to provide reasonably convenient access to schools, places of employment, or services required by the youth, comply with applicable state and local zoning, fire, and sanitary regulations, and be reasonably priced so as to fit within the youth's budget.

"Caseworker" means the person who works directly with children, their families, and other relevant individuals and who has primary responsibility for the development, implementation, and review of the agency's service plans for the child and parents; or who completes foster care or adoptive family home studies or supervises foster family or adoptive placements; or who supervises children placed in approved supervised apartment living arrangements.

"Child" means the same as defined by Iowa Code section 234.1.

"Child-placing agency" means an agency organized within the state of Iowa for the purpose of receiving minor children for placement, supervision, or both in private family homes for foster care; or for adoption; or the placement, supervision, or both of children who are 16 years of age and older living in approved supervised apartment living placements.

"Department" means the department of human services.

"Parent" means custodial and noncustodial parent.

"Safety-related information" means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

"Sibling" means two or more persons having at least one common parent.

"Supervised apartment living placement" means the placement of a child who is at least 16 years of age in an approved living arrangement which provides an environment in which the child can experience living in the community with minimum supervision.

"Volunteer" means any nonpaid person who donates time to an agency, either in working with an individual or groups of clients. A volunteer may also be a student intern.

[**ARC 1754C**, IAB 12/10/14, effective 2/1/15; **ARC 6960C**, IAB 4/5/23, effective 6/1/23]

441—108.2(238) Licensing procedure.

108.2(1) *Right to apply.* Any person or agency has the right to make application for a child-placing license. When applying for a child-placing license, the applicant shall indicate the services for which licensure is being requested.

108.2(2) *Application.* An agency or person applying for a license shall complete Form 470-0723. The application shall be completed and signed by the administrator or the appropriate officer and submitted to the department.

a. The applicant shall report withdrawal of an application to the department within 30 days of the withdrawal decision.

b. Each application shall be evaluated by the department to ensure that all requirements are met.

c. The applicant shall provide requested reports and information relevant to the licensing determination to the department.

108.2(3) *Applications for renewal.* Applications for renewal shall be made to the department at least 30 but no more than 90 days before expiration of the license.

108.2(4) *Notification.* Agencies shall be notified of approval or denial within 90 days of application or reapplication.

108.2(5) *Certificate of license.* The department shall issue or renew Form 470-3623 every three years, without cost, to any child-placing agency which meets the minimum requirements applicable to child-placing agencies as defined by Iowa Code chapter 238 and this chapter. The license shall be posted in a conspicuous place on the licensed premises.

108.2(6) *Provisional license.* A provisional license may be issued to an agency which does not meet all licensing requirements when the failure to meet all licensing requirements does not pose a danger to the health, safety, or well-being of the children being served. It is issued until the agency meets all requirements, up to a maximum time period of one year. A provisional license is issued when the applicant has signed a written statement which includes the following:

a. The deficiencies necessitating the provisional license, including the specific requirements which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the requirements will be met.

108.2(7) *Suspension of a license.* The suspension of a child-placing license prohibits the agency from engaging in any child-placing activities during the period of the suspension. The department shall suspend a license when the agency's failure to meet the requirements poses a danger to the health, safety, or well-being of the children being served. The suspension of a license shall not extend beyond 12 months, and the existence of the condition requiring suspension shall be corrected within a year and documented in the agency's record.

The agency shall submit a written statement for approval by the department. The statement shall include the following:

a. The deficiencies necessitating the suspended license, including the specific requirements which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the requirements will be met.

108.2(8) *Completed corrective action.* When the corrective action plan is completed on or before the date specified on the provisional license or notice of suspension, a full license shall be issued for the remainder of the licensing period.

108.2(9) *Denial or revocation of a license.* The department shall deny an application or reapplication for a license or revoke a license when the applicant fails to meet the licensing requirements or when any of the following conditions exist:

a. The agency is operating without due regard to the health, safety, and well-being of the children being served.

b. A provisional license is not approved.

c. The recipient of a provisional license fails to complete the corrective action plan within the time allowed.

d. An agency with a suspended license fails to complete the corrective action plan on time and a provisional license is not appropriate.

e. The agency misuses public funds.

f. The agency refuses to cooperate with child protective assessments involving children placed by the agency.

g. The agency continuously and significantly violates licensing requirements.

108.2(10) *Method and content of notice.* The notice of denial, revocation, or suspension shall be sent by restricted certified mail pursuant to 441—Chapter 16.

108.2(11) *Right to appeal.* Any agency which disagrees with the department's licensing decision may appeal to the department in accordance with 441—Chapter 7. The appeal shall be filed on or before the thirtieth day following the date of notice of the licensing decision.

[**ARC 5361C**, IAB 12/30/20, effective 3/1/21; **ARC 6960C**, IAB 4/5/23, effective 6/1/23]

441—108.3(238) Administration and organization.

108.3(1) *Statement of purpose.* The agency shall have a written statement of its child-placing philosophy, purpose, and program. The statement shall contain a description of services and methods for service delivery and a description of the persons for whom the services will be provided. The statement shall be available to the public.

108.3(2) *Governing board.* The agency shall have a governing board which, together with the executive, shall be responsible for making policy and for financing and general management of the agency. The governing board may be either the board of directors or the owners of the agency. If the governing board is a board of directors, the following rules shall apply:

a. The agency shall provide for continuity of board membership.

b. The board shall meet regularly for the purpose of ensuring the proper operation of the agency and fulfilling its responsibilities.

c. The minutes of each meeting of the board shall be kept and made a part of the permanent record of the agency.

108.3(3) *Annual report.* A child-placing agency shall require the administrator to submit a written annual report of the agency's activities. The report shall include fiscal and statistical sections indicating receipts and disbursements, number of clients served, and programs. The annual report shall be available to the department.

108.3(4) *Table of organization.* A table of organization, including the identification of lines of responsibility and authority for policy making and service to clients, shall be available to agency staff and to the department.

108.3(5) *Finances.* The licensee shall:

a. Annually develop and implement a plan of financing which is necessary for the operation of the agency in carrying out its programs, ensuring proper care for children, and meeting requirements for licensing.

b. Annually provide either an audit or a detailed financial statement prepared by an independent fiscal agency that provides a review of receipts and disbursements and a statement of fund balances.

c. Retain fiscal records for five years.

108.3(6) *Employment of administrator.* The agency shall employ a qualified administrator and shall delegate to the administrator the responsibility for the administration of the agency. The administrator shall ensure that the mission of the agency and laws relating to the welfare and protection of children are carried out.

108.3(7) *Office space, equipment and supplies.* The agency shall provide and maintain sufficient office space, equipment, and supplies to ensure delivery of services.

441—108.4(238) Staff qualifications.

108.4(1) *Qualifications for all staff.* A child-placing agency employee or volunteer shall be emotionally stable and have the experience and education to perform the duties assigned. The agency

shall not employ any person or give any person direct volunteer responsibility for a child or access to a child when the child is alone if that person has been convicted of a crime involving the mistreatment or exploitation of a child or dependent adult. The agency shall not employ any person or give any person direct volunteer responsibility for a child or access to a child when the child is alone if that person has a record of a criminal conviction or founded child or dependent adult abuse report unless the department has evaluated the crime or abuse and determined that the crime or abuse does not merit prohibition of volunteering or employment. If the child-placing agency is out of state, the agency shall complete that state's child or dependent adult abuse record check and a criminal record check.

a. If a record of criminal conviction or founded child or dependent adult abuse exists, the person shall be offered the opportunity to complete and submit Form 470-2310.

b. In its evaluation, the department shall consider:

(1) The nature and seriousness of the crime or founded abuse in relation to the employment or volunteer position sought;

(2) The time elapsed since the commission of the crime or founded abuse;

(3) The circumstances under which the crime or founded abuse was committed;

(4) The degree of rehabilitation;

(5) The likelihood that the person will commit the crime or founded abuse again; and

(6) The number of crimes or founded abuses committed by the person involved.

c. The agency shall maintain the following information with respect to each staff person:

(1) Documentation that a criminal record check with the Iowa division of criminal investigation has been completed on the staff person prior to the staff person's providing any care or service directly or indirectly to children under the care of the agency. A copy of the department's evaluation of the criminal record check shall be kept in the staff record.

(2) A written, signed and dated statement furnished by the staff person which discloses any founded reports of child or dependent adult abuse on the person that may exist prior to the staff person's providing any care or services to or on behalf of the facility.

(3) Documentation that a child or dependent adult abuse record check of the staff person has been completed with the Iowa central abuse registry for any founded reports of child or dependent adult abuse prior to the staff person's providing any care or services directly or indirectly to children under the care of the agency. A copy of the department's evaluation of this child or dependent adult abuse record check shall be kept in the staff record.

108.4(2) *Contracted employees.* A child-placing agency which contracts for services shall ensure that contracted employees meet the same qualifications, training, and evaluation requirements as those of workers in employed positions. A child-placing agency is responsible for the services provided by contracted providers as well as volunteers and agency employees.

108.4(3) *Qualifications of administrator.* An agency administrator shall possess one of the following:

a. A master's degree in social work, sociology, psychology, guidance and counseling, a related area of human services, education, business administration, or public administration and two years of experience in a public or private social services agency.

b. A bachelor's degree in social work, sociology, psychology, guidance and counseling, a related area of human services, education, business administration, or public administration and four years of experience in a public or private social services agency.

108.4(4) *Caseworker qualifications.* Therapy and counseling services, psychosocial evaluation and assessment and care plan development shall be provided by staff who meet one of the following minimum education and experience criteria:

a. Graduation from an accredited four-year college or university and the equivalent of three years of full-time experience in social work or experience in the delivery of human services in a public or private agency. In addition, these individuals shall have been employed by the agency prior to September 1, 1993. Persons meeting this criterion will not be qualified to provide therapy and counseling if they change place of employment.

b. Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work from a program accredited by the council on social work education.

c. Graduation from an accredited four-year college or university with a bachelor's degree in a human service field related to social work, psychology, or a related behavioral science or in education and the equivalent of one year of full-time experience in social work or experience in the delivery of human services in a public or private agency.

d. Graduation from an accredited four-year college or university with a master's degree in social work or related human service field.

e. Any equivalent combination of graduate education in the social or behavioral sciences from an accredited four-year college or university and qualifying experience up to a maximum of 30 semester hours for one year of the required experience.

108.4(5) *Person filling more than one position.* A person functioning in more than one position specified by these rules shall meet the requirements for each of the positions the person fills.

[**ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6960C**, IAB 4/5/23, effective 6/1/23]

441—108.5(238) Staffing requirements.

108.5(1) *Number of staff.* The agency shall employ a sufficient number of competent staff to perform duties as required by licensing rules for those programs operated by the agency. This shall include the following:

a. Administration of services offered by the agency.

b. Selection and appointment of qualified staff.

c. Provision for staff training.

108.5(2) *Staffing caseload.* The agency shall develop a written policy regarding a staffing ratio based on the workload necessary to provide services in accordance with the agency's program statements. The staffing ratio shall take into consideration all of the following:

a. Qualifications of the caseworkers.

b. Types of children served and their special needs.

c. Types and intensity of services to be provided.

d. Distances involved in provision of services.

e. Other functions or responsibilities of the caseworkers.

441—108.6(238) Personnel administration.

108.6(1) *Personnel policies.* An agency shall develop personnel policies in writing that identify responsibilities of the organization and staff. The policies shall specify hours of work, grievance procedures, sick leave, vacation and all other benefits. A copy of the policies shall be made available to the employee at time of hire.

108.6(2) *Job description and evaluation.* There shall be a written job description for each employee, volunteer, and contracted position identifying duties, qualifications, education, training requirements, and lines of authority. A copy shall be made available to the employees, volunteers, and contracted workers. There shall be a written evaluation of an employee's or contracted worker's performance within six months of being hired or contracted, and annually thereafter.

108.6(3) *Staff training.* An agency shall provide orientation training on the agency's purpose, policies and procedures within one month of hire and 24 hours of training in the first year of employment for all employed and contracted casework staff. The 24 hours of training shall include: training on family foster care services, adoption services, supervised apartment living services, or children and families' mental health topics, and 2 hours of training related to the identification and reporting of child abuse for all employed or contracted casework staff in accordance with Iowa Code section 232.69. An agency shall provide 12 hours of training per year after the first year of employment for all employed or contracted casework staff. The 12 hours of training shall include: training on family foster care services, adoption services, supervised apartment living services, or children and families' mental health topics and child abuse training every three years in accordance with Iowa Code section 232.69.

The training formats that shall qualify as training are as follows: in-service training, seminars, conferences, workshops, institutes, visiting other facilities, and meeting with consultants.

The training provided shall be documented. The documentation shall include the training topic, format, date and number of hours.

108.6(4) *Volunteers.* An agency which utilizes volunteer or student intern staff to work directly with a particular child or group of children shall have a written plan for using these volunteers. This plan shall be given to all volunteer staff and shall indicate that all volunteers are:

a. To be supervised directly by a paid staff member.

b. To be trained and oriented in the philosophy of the agency, the needs of the clients being served, and the methods of meeting these needs.

c. To be subject to the character and reference disclosure and checks required of employed and contracted applicants and employees.

d. To be subject to the same confidentiality rules as paid or contracted staff.

e. To assist and supplement paid staff only, and not replace them.

108.6(5) *Personnel records.* A confidential personnel record shall be maintained for each employee, contracted agent, and volunteer. The record shall contain all of the following information:

a. Name and address.

b. Record of training sessions attended, including dates and content of training.

c. Record of criminal convictions and the department's evaluation of same.

d. Record of founded child or dependent adult abuse reports and the department's evaluation of same.

[**ARC 5361C**, IAB 12/30/20, effective 3/1/21; **ARC 6960C**, IAB 4/5/23, effective 6/1/23]

441—108.7(238) Foster care services.

108.7(1) *Program statement.* An agency authorized to place children in foster care shall have a current written program statement. This statement shall be made available to all agency foster parents, foster children, their parents, referring agencies, and all persons making formal inquiry regarding foster care. The program statement shall include all of the following:

a. Types of foster care provided.

b. Types of children accepted for foster care.

c. Types of services provided to the children, their families, and their foster families.

d. Fees and application costs, if any.

108.7(2) *Agency's authorization to place.* The agency shall obtain a signed placement agreement from the child's custodial parent or legal custodian within 48 hours of placement.

108.7(3) *Preplacement documentation.* Except for emergency placements, a child shall be placed in the agency's foster care program only after the agency determines that its foster care program is an appropriate resource.

108.7(4) *Placement of siblings.* Preference shall be given to placing children from the same family together. If this is not in the best interest of the child, the reasons shall be documented in the child's record.

108.7(5) *Consideration of racial and cultural identity.* Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

108.7(6) *Placement preparation.* An agency shall document the preparation for each child placed in foster care. Preparation shall be appropriate to the child's age, individual needs, the circumstances requiring placement, and the special problems presented. Preparation activities shall, when possible, include:

a. Face-to-face visits.

b. A description provided to the child of the foster family.

c. A description of the child's strengths and needs and safety-related information provided to the foster family. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

d. Any other activities deemed significant.

108.7(7) *Initial placement outline.* If a placement outline is not in the child's case permanency plan, a brief outline documenting all of the following shall be entered in the child's case record within five working days after placement:

a. Name, birthdate, sex, race, and other significant identifying information.

b. Date of placement.

c. Name and address of parents or legal guardian.

d. Names and whereabouts of siblings.

e. Religious preference.

f. Immediate and significant health needs including the child's physical and emotional state at the time of placement.

g. The circumstances leading to the need for foster care.

h. Known previous out-of-home placements.

i. The immediate needs of the child and parents and services to be provided to meet these needs.

j. The name, address, and telephone number of the referring agent or worker.

108.7(8) *Education.* Within ten school days of placement, provisions shall be made by the agency for enrollment of each child of school age into a school program.

108.7(9) *Clothing.* An agency shall make provisions for adequate and individualized clothing for each child admitted into foster care.

108.7(10) *Monthly visit.* Each child in care shall be personally visited by the assigned caseworker at least once a month.

108.7(11) *Parent and child contact.* Provisions for contact between parents and children shall be made except where the parental rights have been terminated or where the court has determined that visits or contact are detrimental to the child.

a. If the mother is breastfeeding the child:

(1) An assessment shall be made whether continuation of breastfeeding is in the best interest of the child; and

(2) A plan shall be developed to support the mother's breastfeeding efforts, if appropriate.

b. The parents and child shall be informed of the contact plan in a manner consistent with their capacity to understand.

108.7(12) *Health and dental program.* An agency shall provide for a complete health and dental program for each child. An agency shall have a written procedure for handling medical emergencies on a 24-hour basis. A copy of the procedure shall be given to each foster home.

a. The agency shall obtain written authorization from the parent or legal guardian to provide medical, psychiatric, dental, anesthesia, immunization, substance abuse evaluation, and emergency surgical treatment. Only the parent or legal guardian shall consent to nonemergency surgery, unless ordered by court. If the child's parent prohibits medical examination, immunization, or treatment based on religious grounds, the agency shall obtain a signed statement from the parent that specifies the prohibitions. In potentially life-threatening situations, the agency shall refer the child's care to appropriate medical and legal authorities.

b. A child shall have a physical examination at least annually. This shall be performed by a licensed physician, physician assistant or licensed nurse practitioner.

c. A child shall have current immunizations as required by the department of public health. If documentation of prior immunization is unavailable, immunizations shall begin within 30 days of placement, unless contraindicated and unless a statement from a physician to that effect is included in the child's medical record. A statement from physician, referring agency, parent, or guardian indicating immunizations are current is sufficient documentation of immunizations.

d. An agency shall provide for dental examinations and treatment; the initial referral at 12 months of age, the next at 24 months of age, then every 6 months.

e. A health record shall be maintained for each child and shall include all of the following:

(1) Authorization for medical care.

(2) A medical history and copies of required physical examinations.

(3) A record of medical and dental care, treatment and prescribed medication, immunizations, accidents requiring medical treatment, and hospitalizations. At the time of discharge from agency foster care, a summary of this record shall be provided to the legal custodian. Information about drug evaluation or treatment, venereal disease tests, HIV tests, and pregnancy tests shall be excluded.

108.7(13) *Service plan development and review.* The provider shall develop and revise service plans for each child in placement. An initial service plan shall be developed within 30 calendar days of placement

in foster care. The provider shall identify qualified persons to monitor the services identified in the service plan to ensure that the plan continues to be necessary, appropriate, and addresses the permanency goal. Service plans shall be developed and reviewed as follows:

a. The service plan shall be developed and revised in collaboration with the referral worker, child, family, and the foster parents unless the service plan contains documentation for the treatment rationale for the lack of involvement of one of these parties. The provider shall document the dates and content of the collaboration on the initial and revised service plans. The provider shall provide a copy of the initial and revised service plans to the child's parent and the referring agency, unless otherwise ordered by the court. The initial and revised service plan shall identify the following:

(1) Strengths and needs of the child and parents.

(2) Goals, which are statements of outcomes to be achieved in meeting the needs of the child including the child's permanency needs.

(3) Objectives, which are specific, measurable and time-limited statements of indicators, levels of competence, or accomplishments which are necessary for progress toward each goal.

(4) Specific treatment service activities to be provided to achieve the objectives.

(5) Designation of the persons responsible for providing the services.

(6) Date of initiation and service plan development.

(7) Anticipated duration of services.

b. All service plans shall be reviewed 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services or when the needs of the child or the services necessary for the parents to meet the needs of the child have changed and these changes significantly affect goals, objectives and service activities. The review shall determine if the services continue to be necessary, appropriate and consistent with the child's permanency goal. The reviewer shall revise the service plan to reflect the services that are necessary, appropriate, and consistent with the child's permanency goal.

108.7(14) *Information for foster parents.* At the time of placement, an agency shall provide foster parents with all of the following if known:

a. Name of the child, agency caseworker, and referring agency.

b. Information about the child's known behavioral characteristics including safety-related information, needs, and plans for the child and family. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court, or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. Written consent to obtain routine, nonsurgical medical care and to authorize emergency medical and surgical treatment, anesthesia, and immunizations for each child placed in the foster home.

d. A copy of the child's current physical examination and medical history when completed.

As this information becomes available to the agency, foster parents shall be informed immediately.

108.7(15) *Religious policy.* The agency shall have a written policy on religious participation and training for foster children. The agency shall provide the policy to parents and foster parents and shall ensure that the policy is adhered to in each foster home.

108.7(16) *Mail.* There shall be a written policy which ensures that foster children are permitted to send and receive mail, unless documented that this practice is contraindicated.

108.7(17) *Allowance policy.* An agency shall have a written policy addressing payment of and accounting for personal allowances for foster children.

108.7(18) *Reporting hospitalization or death of child.* Any serious injury or illness requiring hospitalization of a child in care shall be reported to the parent and the responsible agency as soon as possible. Efforts to notify parents and responsible agency staff shall be documented in the child's record. The death of a child shall be reported immediately to the parent or next of kin and to the referring agency.

108.7(19) *Foster care records.* The agency shall maintain confidential individual records for each child placed in a foster home. The record shall include:

a. The initial placement outline. (Refer to subrule 108.7(7).)

b. All legal documents pertaining to the child.

c. The child's health record, including psychological and psychiatric reports.

d. The summary narrative which reflects the dates and content of the caseworker's contact regarding the child.

e. Educational records and reports.

f. All service plans developed by the agency.

g. Case permanency plans developed by the referring agency.

h. A record of foster placements made by the agency including foster parents' names and addresses and dates of placements.

108.7(20) *Termination of foster care.* When a foster care placement is terminated, all of the following information shall be documented in the child's record within 30 days:

a. Reason for termination.

b. Current location of the child, unless the child was placed for adoption. In that case the record shall state only that the child was placed for adoption and shall not disclose the identity of the adoptive family unless the adoptive family agrees to disclosure of identity prior to finalizing of adoption.

c. Steps remaining to achieve permanency plan goal.

d. Provisions for follow-up, if any.

e. For unplanned terminations, a summary explaining the circumstances.

[**ARC 6960C**, IAB 4/5/23, effective 6/1/23]

441—108.8(238) Foster home studies. The agency shall provide information to prospective foster parents about foster care, agency policies, licensing requirements for foster care, the children needing foster care, the licensing process and the reimbursement rates.

108.8(1) *Licensing procedures.*

a. Availability of applications. The agency may provide Form 470-0689 to anyone requesting to be licensed.

b. Licensing study. The agency may complete a licensing study of the family.

c. New applications. If the child-placing agency decides to complete the initial licensing study, the agency shall submit to the department all documents and information required by 441—Chapter 113 pertaining to the licensing and regulation of foster family homes. This shall include a narrative evaluation of the foster family home which reflects a thorough study of each foster family. The narrative shall document at least two face-to-face interviews with the prospective foster family and at least one face-to-face interview with each member of the household before the placement of a child. At least one interview shall take place in the applicant's home. The narrative summary of the family study shall assess all of the following:

(1) Motivation for foster care.

(2) Family's and extended family's attitude toward accepting foster children.

(3) Family's attitude toward foster children's parents.

(4) Emotional stability, physical health, and compatibility of foster parents, and ways they cope with change and stress.

(5) Adjustment of own children, if any.

(6) Assessment of the child-caring skills, including disciplinary techniques used.

(7) Strengths and weaknesses of each member of the household.

(8) Types of children desired.

(9) Type of children, if any, for whom placement with the family would be appropriate.

(10) Recommendation as to the number, age, sex, characteristics, and special needs of children best served by this family.

(11) Assessment of the need for training and a plan for providing the needed training.

(12) Any other pertinent information that might assist the agency in making the licensing recommendation.

(13) Record checks. The licensed child-placing agency shall submit record checks for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether they have any founded child or dependent adult abuse reports or criminal convictions or have been placed on the sex offender registry. The licensed child-placing agency shall use Form 470-0643 and Form 595-1396 for this purpose. The department's contractor for the recruitment and retention of resource

families shall assist applicants in completing required record checks, including fingerprinting. Any criminal or abuse records discovered shall be evaluated according to the procedures in rule 441—113.13(237).

(14) Health of foster parents and impact of medical conditions on their ability to foster a child.

(15) Income information.

(16) Documentation that at least three references have been received and the responses reviewed.

108.8(2) *Licensing decision.* The department shall make the licensing decision and notify the applicant and the child-placing agency within 30 days of the licensing decision. In no case shall a child be placed in a foster home before licensing approval.

a. A full license shall be issued to foster families meeting all necessary criteria for a full licensure.

b. A provisional license may be issued for up to one year if the foster family fails to meet all requirements for licensure. When an agency recommends, because of rule violation, that a foster home receive a provisional license at the time the license is issued or renewed, the agency shall document the violation in the foster home file, and shall send the following to the department:

(1) A copy of the assessment of the rule violation and recommendation.

(2) A copy of the foster home's plan to achieve rule compliance within stipulated time frames.

c. When an agency recommends that a foster home license be denied or revoked, the agency shall send the following documents to the department:

(1) A copy of the assessment of rule compliance and the foster family's reaction to the assessment.

(2) The agency's recommendation and supporting rationale.

(3) Other appropriate documents supporting the findings.

108.8(3) *Reapplications.* At least 30 days before the expiration of the license, the agency shall submit all documents and information required by 441—Chapter 113 pertaining to the licensing and regulation of foster family homes. This shall include an update of the narrative noting any changes that may have occurred in the foster family's living arrangement or life style and any other pertinent information that might assist in making the licensing decision, including an assessment of the foster family's ability to provide foster care.

108.8(4) *Unannounced visits.* The agency shall conduct at least one annual unannounced visit to each licensed foster family home the agency inspects to meet the requirements of Iowa Code section 237.7.

108.8(5) *Complaints.* When an agency receives a complaint which may indicate possible violation of the foster care licensing rules, the agency shall, within five working days of receiving the complaint, either conduct an investigation to assess compliance with applicable rules or refer the complaint to the department for assessment. If the agency conducts the investigation, the agency shall submit a written report of the investigation to the department within ten working days of receiving the complaint with a statement of rule violation and a recommendation regarding the license of the foster family home. The written report shall be filed in the foster parents' file.

108.8(6) *Foster family training.* The agency shall ensure that each foster home recommended for foster family license has complied with the training requirements in rule 441—113.8(237).

Prior to licensure and every three years thereafter, each foster parent shall obtain mandatory reporter training relating to identification and reporting of child abuse.

108.8(7) *Placement agreement.* When a child is placed with a foster family, the agency shall have a signed agreement with each foster family home including the expectations and responsibilities of both the agency and the foster family, the services to be provided, and the financial arrangements for children placed in the home.

108.8(8) *Foster family home records.* The agency shall keep separate records for each foster family home. The agency shall begin the record at the time of application. Foster family home records shall contain:

a. The application.

b. Family assessment.

c. Most recent medical reports on foster family members.

d. Summary of dates and content of worker's contacts relating to licensing or relicensing.

e. Reference letters.

f. Annual assessment of strengths and weaknesses of the foster family relative to the care of individual children placed with them.

[**ARC 5361C**, IAB 12/30/20, effective 3/1/21; **ARC 6960C**, IAB 4/5/23, effective 6/1/23]

441—108.9(238) Adoption services.

108.9(1) *Program statement.*

a. An agency licensed to place children for adoption shall have a current written program statement which shall include all of the following:

(1) Characteristics of children to be placed.

(2) Eligibility requirements for adoptive families.

(3) Services provided during the adoption process.

(4) Services to the birth parents upon relinquishment.

(5) Postadoption services to adoptive families, if offered.

(6) Explanation of all fees and any other costs for which the adoptive family is responsible for payment.

(7) A statement that payment of fees does not ensure adoption approval.

b. The program statement shall be made available to referring agencies and to all persons making formal inquiry regarding adoption.

108.9(2) *Services to birth families.* An agency which offers services to birth parents who are considering relinquishing a child for adoption shall provide the following:

a. Intake process. When an agency agrees to provide services to the birth parents, intake interviews shall be conducted, including provision of information to the birth parents regarding the adoption process and their rights and role.

(1) When an agency completes a background information investigation report on the child to be adopted, a personal interview with each parent of the child must be completed unless a parent's identity or whereabouts is unknown.

(2) If a parent's identity or whereabouts is unknown, as much information as possible shall be obtained from the other parent or other sources if available.

b. Background information on birth parents. The agency shall obtain as much information as possible about birth parents that includes, but is not limited to:

(1) Birth parents' strengths and needs.

(2) Birth parents' physical description.

(3) Birth parents' and extended family members' medical and mental health history.

(4) Parents' criminal history.

(5) Birth parents' educational level.

(6) An affidavit signed by the birth parents instructing the court to reveal, or not reveal, their names to the child pursuant to Iowa Code chapter 600.

(7) Any additional information the birth parents wish to include in the child's adoption record.

c. Background information for an infant adoption. Information shall be obtained that includes, but is not limited to, the following:

(1) The child's due date.

(2) Prenatal care received by the mother during pregnancy.

(3) Risk factors that may affect the child's health after birth.

(4) Birth records following the child's birth, if available.

d. Background information on an older child. Information shall be obtained that includes, but is not limited to the following:

(1) The child's legal status.

(2) The child's physical description, medical and mental health history, developmental information, and other pertinent information necessary for a child study.

(3) Identification of any specific and unique needs of the child and the type of family to be considered for adoptive placement.

(4) The involvement of the birth parents and significant others in the child's care.

e. A copy of the background information of the child and birth parents shall be provided to the prospective family before placement of the child.

f. Birth parent counseling. If accepted by the birth parents, the counseling shall be provided after the birth of the child and prior to the signing of a release of custody that meets the requirements of Iowa Code chapter 600A or prior to the filing of a petition for termination of parental rights.

(1) The purpose of the counseling is to:

1. Provide information about options to assist birth parents in making an informed decision regarding release of custody.

2. Assist birth parents in resolving emotional issues related to separation and loss.

(2) Counseling shall be provided to birth parents only by the following persons:

1. Certified adoption investigators.

2. Mental health professionals who have the equivalent of two years of adoption work experience in the direct provision of adoption services.

3. Private agency staff with two years of adoption work experience in the direct provision of adoption services.

4. Department staff with two years of adoption work experience in the direct provision of adoption services.

(3) Forms. All forms used to execute a release of custody shall comply with the requirements of Iowa Code chapters 600 and 600A.

(4) Affidavit and documentation. The person providing the counseling shall complete the Counseling Affidavit to certify that the counselor has provided the birth parent with the requested counseling or that the birth parent has refused counseling. The Counseling Affidavit and documentation that the person providing the counseling is qualified to provide the requested counseling shall be attached to the release of custody. Documentation shall include one of the following:

1. A copy of a professional license, when applicable.

2. A record of all adoption work experience, including dates and location. In addition, the person providing counseling shall provide the names of the counselor's employers and supervisors to enable the court to verify the counselor's adoption work experience.

108.9(3) *Preparation of child for adoptive placement.* Preparing a child, especially an older child, includes activities designed to enable a child to make a transition to an adoptive placement. The activities shall include, but are not limited to:

a. Counseling regarding issues of separation, loss, grief, guilt, anger and adjustment to an adoptive family.

b. Preparation of a life book.

c. Provision of age-appropriate information regarding community resources available, such as children's support group to assist the child in the transition and integration into the adoptive family.

108.9(4) *Services to adoptive applicants.*

a. Application process. Before proceeding with an adoptive home study, the agency shall have received an application for adoption from the person or persons wishing to adopt a child. The application form shall include information about the applicant's intent to become an adoptive parent, and the basic data about the applicant's family, home, financial status, health, and references.

b. Explanation of the adoption process. The agency shall provide the applicant an explanation of the entire adoption process, including the legal procedures, the agency policies and procedures regarding placement of children, and the children available for adoption.

c. Adoptive home study. The home study consists of a family assessment which shall include at least two face-to-face interviews with the applicant and at least one face-to-face interview with each member of the household. At least one interview shall take place in the applicant's home. The assessment shall include, but need not be limited to, the following:

(1) Motivation for adoption and whether the family has biological, adopted or foster children.

(2) Family and extended family's attitude toward accepting an adopted child, and plans for discussing adoption with the child.

(3) The attitude toward adoption of other people involved with the family in a significant way.

(4) Emotional maturity; marital history, including verification of marriages and divorces; assessment of marital relationship; and compatibility of the adoptive parents.

(5) Ability to cope with problems, stress, frustrations, crises, separation and loss.

(6) Medical, mental, or emotional conditions which may affect the applicant's ability to parent a child.

(7) Ability to provide for the child's physical and emotional needs and to respect the child's cultural and religious identity.

(8) Description of biological and previously adopted children, if any, including their attitudes toward adoption, relationship with others, and school performance.

(9) Capacity to give and receive affection.

(10) Statements from at least three references provided by the family and other unsolicited references that the agency may wish to contact.

(11) Attitudes of the adoptive applicants toward the birth parents and the reasons the child is available for adoption.

(12) Income information, including the family's ability to financially provide for a child.

(13) Disciplinary practices that will be used.

(14) History of abuse involving family members, including how the abuse was addressed and how that history impacts the applicant's ability to be an adoptive parent.

(15) Assessment of, commitment to, and capacity to maintain other significant relationships.

(16) Substance use or abuse by members of the household, treatment history and current status of treatment.

(17) Recommendations for the number, age, sex, characteristics, and unique needs of children best parented by this family.

(18) The family's ability to anticipate and understand the unique needs of an adopted child as the child gets older and how the family will manage those needs.

d. Record checks. The licensed child-placing agency shall perform record checks for each applicant and for the other persons living in the home of the applicant as follows:

(1) The records of the applicants shall be checked:

1. On the Iowa central abuse registry using Form 470-0643;
2. By the Iowa division of criminal investigation, using Form 595-1396;
3. On the Iowa sex offender registry;
4. On the child or dependent adult abuse registry of any state where the applicant has lived during the five years prior to the issuance of the investigative report; and
5. For a national criminal history through fingerprinting or another biometric identification-based process accepted by the federal government.

(2) The records of persons aged 14 or older living in the home of the applicant shall be checked:

1. On the Iowa central abuse registry using Form 470-0643;
2. By the Iowa division of criminal investigation, using Form 595-1396; and
3. On the Iowa sex offender registry.

(3) Out-of-state child and dependent adult abuse checks and national criminal history checks may be completed on any adult in the home of the applicant if the certified adoption investigator has reason to do so.

(4) The agency shall not approve a prospective applicant and the department shall not perform an evaluation if the applicant or anyone living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."*

(5) The agency shall not approve a prospective applicant and shall not perform an evaluation if the applicant or anyone living in the home of the applicant has committed a crime in a state other than Iowa that would be a forcible felony if the crime would have been committed in Iowa, as set forth in Iowa Code section 600.8(2)*"b."*

e. Evaluation of record. If the applicant or anyone living in the home has record of founded child or dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the applicant shall not be approved to adopt unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

(1) The evaluation shall consider the nature and seriousness of the founded abuse or crime in relation to adoption, the time elapsed since the commission of the founded abuse or crime, the circumstances under which the abuse or crime was committed, the degree of rehabilitation, the likelihood that the person will commit the abuse or crime again, and the number of abuses or crimes committed by the person.

(2) The person with the criminal conviction or founded child or dependent adult abuse report shall complete and return Form 470-2310 within ten calendar days of the date on the form to be used to assist in the evaluation. Failure of the person to complete and return the form within the specified time frame may result in a written denial of approval for adoption.

(3) If the applicant, or anyone living in the home of the applicant, has been convicted of a simple misdemeanor or a serious misdemeanor that occurred five or more years prior to application, the evaluation and decision may be made by the department's centralized service area. The department's centralized service area shall notify the applicant of the results of the evaluation.

(4) If the applicant, or any person living in the home of the applicant, has a founded child or dependent adult abuse report, has been convicted of an aggravated misdemeanor or felony at any time, or has been convicted of a simple or serious misdemeanor that occurred within five years prior to application, the licensed child-placing agency shall initially conduct the evaluation.

1. If the licensed child-placing agency determines that the abuse or crime does warrant prohibition of approval, the licensed child-placing agency shall notify the applicant of the results of the evaluation in writing. The notice shall contain information on appeal rights pursuant to 441—Chapter 7.

2. If the child-placing agency determines that the applicant should be approved despite the abuse or criminal conviction, the agency shall provide copies of Form 470-2310 and the written notice to the applicant to the Administrator, Division of Adult, Children and Family Services, Department of Human Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Within 30 days, the administrator shall determine whether the abuse or crime merits prohibition of approval and shall notify the child-placing agency in writing of that decision.

f. Agency decision. The licensed child-placing agency shall notify the applicant in writing no later than 30 days after completion of the home study of the agency's decision regarding approval for placement of a child.

(1) If the applicant is denied approval, the agency shall state the reasons for denial in the written decision.

(2) The agency worker and supervisor shall date and sign the adoptive home study.

(3) The agency shall provide a copy of the home study to the family at the time the written notice is sent.

(4) An agency shall not place a child in an adoptive home before the family is approved, or before a placement agreement is signed by the family and the agency.

(5) A home study shall be valid for up to two years from the date signed by the agency worker and supervisor.

g. Denial. The licensed child-placing agency shall deny approval of an adoption application when:

(1) The applicant or any other person living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."*

(2) The minimum standards set forth in these rules are not met and cannot be corrected.

(3) The applicant or any person residing in the home has been convicted of a crime, unless an evaluation of the crime has been made by the department which concludes that the crime does not merit prohibition of approval.

(4) The applicant or any person residing in the home has a record of founded child or dependent adult abuse, unless an evaluation of the founded child or dependent adult abuse has been made by the department which concluded that the founded child or dependent adult abuse does not merit prohibition of approval.

(5) The application is fraudulent, which means the applicant has knowingly made false statements or has knowingly concealed information that is material to the investigation.

h. Updates. To remain valid, an update to the home study shall be completed no later than 24 months from the previous home study or previous home study update. The update shall be conducted by completion of the following:

(1) The child and dependent adult abuse and criminal history record checks, except for the national criminal history check, shall be repeated. Any abuses or convictions of crimes since the last record check shall be evaluated using the same process.

(2) A minimum of one home visit shall be conducted with the approved adoptive family.

(3) The information in the approved adoptive home study shall be reassessed.

(4) A written report of the assessment and updated adoptive home study shall be completed, dated, signed by the agency worker and the agency supervisor, and provided to the adoptive family.

i. Annual visits to the adoptive home. The agency shall complete a minimum of one visit each year in the homes of families approved to adopt by the agency.

(1) The visit shall include, but not be limited to, assessment of the following areas:

1. Home environment.
2. Persons present at the time of the visit.
3. Changes in the home or household members, or other areas addressed in the home study.

(2) When a person aged 14 or older moves into the home, the agency shall perform checks on the Iowa central abuse registry, by the division of criminal investigation, and on the sex offender registry. The record check evaluation process shall be completed if the person has a criminal conviction or founded child or dependent adult abuse report or is on the sex offender registry.

(3) The findings from the visit shall be documented and maintained in the file.

108.9(5) *Services to adoptive families.*

a. Preparation of the family includes activities designed to prepare the adoptive family for the placement of a particular child. These activities shall assist the adoptive family in expanding its knowledge and understanding of the child and enhance the family's readiness to accept the child into the family and encourage the family's commitment. The activities shall include, but not be limited to:

(1) Providing background information on the child and the birth family, including a child study.

(2) Providing information regarding the unique needs and characteristics of the child.

(3) Providing information regarding an older child's anticipated behavior.

(4) Discussing the impact that adding a new member to their family may have on all current family members.

(5) Discussing the issues of separation, loss, grief, anger, and guilt that adoptive children experience at various developmental stages.

(6) Providing the family with community resources that are available, such as support groups.

b. Preplacement services include the preplacement visits of the child and approved family and any activities necessary to plan, conduct, and assess these transitional visits before the placement of the child in the adoptive family's home for the purpose of adoption.

c. Postplacement services include postplacement supervision, support, crisis intervention, and required reports to the court. The postplacement services are provided from the time the child is placed with an approved adoptive family until finalization of the adoption occurs.

(1) No fewer than three face-to-face postplacement visits in the family's home are required.

(2) At a minimum the first visit shall be completed within 30 days after placement; the second visit within 90 days after placement; and the final visit before granting consent to adopt no later than 180 days after placement.

(3) Postplacement visits shall be completed as often as necessary if the adoptive family is experiencing problems, and may extend to finalization or beyond 180 days if additional time is needed.

d. Postplacement supervision. The agency shall provide postplacement supervision to assess the unique needs of the child including, but not limited to, the following areas:

(1) Integration and interaction of the child with the family.

(2) Changes in the family functioning which may be due to the child's placement.

(3) Social and emotional adjustment of the child.

(4) Child's growth and development since placement with the adoptive family.

(5) Changes and adjustments that have been made in the family since the child's placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

(8) School adjustment of a child who is attending a school.

(9) The behavioral needs of the child.

(10) The psychological and mental health needs of the child.

(11) Services and supports that will assist the family in the future.

e. Postadoption services. The agency shall provide postadoption services to adoptive parents and adoptees, or shall refer adoptive parents and adoptees to other community resources for the services.

f. Postplacement reports. The agency worker shall prepare a written report based on observations made during each home visit. Each report shall address the specific needs of the child and the family's ability to meet those needs. The reports shall be used by the agency in making a written recommendation to the court regarding finalization of the adoption.

108.9(6) *International adoptions.*

a. International adoptions preplacement investigation. Preplacement investigations for the purpose of international adoptions shall meet the requirements of the United States Citizenship and Immigration Services.

b. International adoptions postplacement report.

(1) For an adoption based on a decree issued by a foreign jurisdiction within the United States, the agency shall conduct a postplacement investigation and issue a postplacement report as required in subrule 108.9(5).

(2) For an adoption based on a decree issued by a jurisdiction outside the United States, an investigator shall conduct a postplacement investigation that consists of a minimum of three face-to-face visits with the minor person and the adoptive parents during the first year after placement with the first such visit to be conducted within 60 days of the placement of the minor person in the adoptive home. Additional visits shall be conducted if required by the jurisdiction that issued the decree.

(3) The postplacement investigation and report under this subrule shall include documentation that any unique needs of the minor person are being met appropriately through the placement.

108.9(7) *Religious policy.* There shall be a written policy on religious participation for prospective placing parents, adoptive parents, and adoptees. The policy shall be made available to referral sources as well.

108.9(8) *Adoption records.* The agency shall keep separate records for each prospective, approved, or active adoptive family. Contents of these records shall be as follows:

a. The application.

b. The adoptive home study.

c. Current medical records.

d. All references.

e. All legal documents pertaining to the adoption.

f. Birth family information and background report, including physical descriptions, medical and mental health history, educational level, developmental history, problem areas such as substance or alcohol abuse.

g. Summary narrative on the placement decision and the preplacement and postplacement contacts with the adoptive family and child.

h. Information pertaining to the child including, but not limited to: physical, medical, and mental health; problem areas, including verification of the child's special needs; and whether or not a referral was made to the department for adoption subsidy.

i. In the event a family is not approved for placement of a child, the narrative shall clearly indicate the reason.

j. In the event a family is approved, but no child is placed with them, the narrative shall clearly indicate the reason.

108.9(9) *Right to appeal.* An adoptive applicant or an adoptive family may appeal an adverse decision made by a licensed agency pursuant to 441—Chapter 7. The appeal shall be filed with the department within 30 days of the notice of decision to the applicant or family by the licensed agency.

108.9(10) *Disposition of records.* When an adoption has occurred, the agency must maintain all records regarding the child, the birth family, and the adoptive family or families, forever. Any subsequent information received following the adoption finalization shall be placed in the adoption record. If the agency closes, all adoption records shall be forwarded to the department.

[**ARC 1754C**, IAB 12/10/14, effective 2/1/15; **ARC 6960C**, IAB 4/5/23, effective 6/1/23]

441—108.10(238) Supervised apartment living placement services. An agency seeking to obtain a child-placing license which authorizes the agency to place or supervise children in supervised apartment living placements shall meet the standards in rules 441—108.2(238) to 441—108.6(238).

108.10(1) *Program statement.* An agency authorized to place or supervise children in supervised apartment living placements shall have a current written program statement which shall be provided to all children placed in supervised apartment living. The statement shall include all of the following:

a. A description of the types of living arrangements approved by the agency.

b. The eligibility requirements for the children who may be placed in a supervised apartment living placement.

c. The means of financial support for the children.

d. The expectations the agency has for children while placed in a supervised apartment living placement.

e. Services provided to the children.

f. Provisions for emergency medical care.

g. A description of the education and community activity options that are available.

108.10(2) *Basis for placement.* Before placing a child in supervised apartment living, an agency shall document all of the following:

a. The child is at least 16 years of age.

b. An initial assessment has been made that identifies the child's strengths and needs as these pertain to the child's ability to live independently.

c. The child has the capacity to function outside the structure of a foster family or group care setting.

d. The selection of a supervised apartment living placement is the most appropriate placement for the child.

e. The child will be involved in school or an educational or vocational program, work, or a combination thereof, as indicated in the child's individual service plan.

f. The child has entered into a mutually agreed-upon written contract with the agency which specifies the responsibilities of the agency and the child. This contract shall be reviewed with the child quarterly.

g. The agency has determined, through a visit to the living arrangement, that the following minimum standards for approval have been met:

(1) The living arrangement provides reasonably convenient access to schools, places of employment, and services required by the child.

(2) The living arrangement is in compliance with the applicable state and local zoning, fire, sanitary, and safety regulations.

(3) The living arrangement is reasonably priced to fit within the child's budget.

h. The agency has determined, based on the criteria in this subrule, that the agency's program can meet the needs of the child.

108.10(3) *Services provided.* The following services are required:

a. Ongoing assessment that identifies the child's strengths and needs as these pertain to the child's ability to live independently.

b. Development of an individual service plan by the agency worker within 30 days of the child's placement. The service plan shall be developed in consultation with the child, the child's family (unless a reason for noninvolvement is documented in the case record), and referring worker and shall be signed by all involved. The individual service plan shall be reviewed and updated quarterly or more often as necessary and shall be signed by all involved. The plan shall document the following:

(1) The goals that are intended to meet the specific needs of the child and the projected dates of accomplishment.

(2) The objectives (action steps) to be taken by the child and the agency and the projected dates of accomplishment to meet the child's goals.

(3) The services and activities necessary to achieve the child's goals and facilitate objectives (action steps), the frequency of services or activities, and the persons responsible.

(4) A budget, developed with the child, based upon the child's monthly maintenance payment, any start-up allowance, and any earned or unearned income or assistance (such as food assistance). The agency worker shall work with the child to ensure that needed items are purchased and that bills are paid.

(5) In the quarterly update, the child's progress toward the goals and objectives and the child's compliance with the service plan.

c. Supervision to assist the child in developing the needed structure to live in this setting and in locating and using other needed services. Supervision shall include guidance, oversight, and behavior monitoring.

(1) If the child is under age 18, supervision shall include a minimum of weekly face-to-face contacts.

(2) For children aged 18 or older, supervision shall include face-to-face contact at least every other week.

(3) Agency staff shall be present on site in a cluster setting at any time when more than one child is present in the living arrangement and shall be available to the children 24 hours a day, seven days a week.

(4) The agency shall provide personal care items for youth, and these items shall reflect the individual, cultural, racial, and ethnic needs of the youth living in the agency's program.

(5) The agency shall provide a means for children in a scattered site setting to contact agency personnel 24 hours per day, seven days per week.

(6) The agency shall ensure that each child has access to and is receiving necessary medical care.

d. Documented observation by the agency worker that:

(1) The living situation is an environment that allows for the child's social and emotional needs to be met;

(2) There is an operating smoke alarm on each level of occupancy;

(3) The child has access to a telephone; and

(4) There is no reasonable cause for believing that the child's mode of living presents any unacceptable risks to the child's health or safety.

108.10(4) *Record.* In addition to any other documentation requirements, an agency shall maintain a record for each child in a supervised apartment living placement. The record shall contain all of the following:

a. The name, date of birth, sex, and address of the child and information on how the child can be contacted.

b. Documentation of financial support sufficient to meet the child's housing, clothing, food, and miscellaneous expenses.

c. Name, address, and telephone number of guardian, if applicable, and referring worker.

d. Medical records.

e. Educational and employment records.

f. All of the individual service plans and updated reviews.

g. Documentation of visits.

108.10(5) *Staffing requirements.* Each child in a supervised apartment living placement shall receive an agreed-upon number of hours of casework services per month. This shall be recorded in the child's individual service plan.

[**ARC 8901B**, IAB 6/30/10, effective 9/1/10; **ARC 9730B**, IAB 9/7/11, effective 11/1/11; **ARC 6960C**, IAB 4/5/23, effective 6/1/23]

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CHAPTER 109
CHILD CARE CENTERS

[Filed as Chapter 108, 2/14/75 and renumbered 7/1/75]
[Prior to 7/1/83, Social Services[770] Ch 109]
[Prior to 2/11/87, Human Services[498]]

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

441—109.1(237A) Definitions.

"Adult" means a person 18 years of age or older.

"Child" means the same as defined in Iowa Code section 237A.1.

"Child care" means the same as defined in Iowa Code section 237A.1.

"Child care center" or *"center"* means the same as defined in Iowa Code section 237A.1. For the purposes of this chapter, the word "center" applies to a child care center or preschool unless otherwise specified.

"Child care facility" or *"facility"* means the same as defined in Iowa Code section 237A.1.

"Coaching" means a relationship-based process led by an expert to build capacity for specific professional dispositions, skills and behaviors and is focused on performance-based outcomes.

"Education" means formal coursework offered through a state-approved accredited secondary school, college or university.

"Facility" means a building or physical plant established for the purpose of providing child day care.

"Get-well center" means a facility that cares for a child with an acute illness of short duration for short enrollment periods.

"Involvement with child care" means the same as defined in Iowa Code section 237A.1.

"Parent" means parent or legal guardian.

"Person subject to an evaluation" means the same as defined in Iowa Code section 237A.5.

"Preschool" means the same as defined in Iowa Code section 237A.1.

"Professional development" means a continuum of learning activities designed to prepare and support individuals for work with children and families, including coaching, education, and training.

"Regulatory fee" means the amount payable to the department for licensure of a child care center based on the capacity of the center.

"Requesting entity" means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can have involvement with child care. The requesting entity must be a child care facility as defined in Iowa Code section 237A.1.

"Serious injury" means the same as defined in Iowa Code section 702.18.

"Training" means a learning experience that addresses a specific topic of professional relevance that builds or enhances knowledge.

"Transgression" means the same as defined in Iowa Code section 237A.5.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.2(237A) Licensure procedures.

109.2(1) *Application for license.*

a. Any adult or agency has the right to apply for a license. The application for a license must be made to the department on a department-provided application for a license to operate a child care center.

b. Requested reports, including the fire marshal's report and other information relevant to the licensing determination, will be furnished to the department upon application and renewal.

c. A center must submit all required fingerprints to the department of public safety before the issuance or renewal of the center's license.

d. When a center makes a sufficient application for an initial license, the center may operate for a period of up to 120 calendar days from the date of issuance of the form granting permission to open without a license, pending a final licensing decision. A center has made a sufficient application when it has had an on-site visit and has submitted the following to the department:

(1) An application for a license.

(2) An approved fire marshal's report.

(3) A floor plan indicating room descriptions and dimensions, including location of windows and doors.

(4) Information sufficient to determine that the center director meets minimum personnel qualifications.

e. Applicants must submit the regulatory fee as specified in subrule 109.2(5) to the department.

f. Applicants must be notified of approval or denial of initial applications within 120 days from the date the application is submitted.

(1) If the applicant has been issued a form granting permission to open without a license, the applicant must be notified of approval or denial within 120 calendar days of the date of issuance of the form.

(2) No full or provisional license will be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(5).

g. The department will not act on a licensing application for 12 months after an applicant's child care center license has been denied or revoked.

h. When the department has denied or revoked a license, the applicant or person is prohibited from involvement with child care unless the department specifically permits involvement through a record check decision.

109.2(2) *License.*

a. An applicant showing compliance with center licensing laws and these rules, including department approval of center plans and procedures and submission of the regulatory fee as specified in subrule 109.2(5) to the department by the date due, shall be issued a license for 24 months. In determining whether or not a center is in compliance with the intent of a licensing standard outlined in this chapter, the department will make the final decision.

b. A new license must be applied for when the center moves, expands, or the facility is remodeled to change licensed capacity.

c. A new license must be applied for when another adult or agency assumes ownership or legal responsibility for the center.

d. A provisional license may be issued or reduced pursuant to Iowa Code section 237A.2.

109.2(3) *Denial.* Initial applications or renewals will be denied when:

a. The center does not comply with center licensing laws and these rules in order to qualify for a full or provisional license.

b. The center is operating in a manner that the department determines impairs the safety, health, or well-being of children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided either orally or in writing to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The center is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(5) is not received by the department within 60 calendar days from the due date on the invoice.

109.2(4) *Revocation and suspension.* A license will be revoked or suspended if corrective action has not been taken when:

a. The center does not comply with center licensing laws or these rules.

b. The center is operating in a manner that the department determines impairs the safety, health, or well-being of the children in care.

c. A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

d. Information provided to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

e. The facility is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal, fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

f. The regulatory fee as specified in subrule 109.2(5) is not paid in full due to insufficient funds to cover a check submitted to the department for the fee.

109.2(5) *Regulatory fees.* A fee based upon center capacity is due to the department at the time of issuance of the license in accordance with this subrule.

a. Fee structure. The amount of the fee is based on the capacity of the center as indicated below:

Center Capacity	Fee Amount
0 to 20 children	$50
21 to 50 children	$75
51 to 100 children	$100
101 to 150 children	$125
151 or more children	$150

b. Determination of capacity. The licensing consultant must determine center capacity by dividing the amount of usable space by the amount of space required per child as specified in subrule 109.11(1). Upon approval by the department, the final determination of center capacity may include evaluation of other factors that influence capacity, as long as physical space requirements per child as defined in subrule 109.11(1) are maintained.

c. Notification. Upon final determination of center capacity by the licensing consultant, the licensing consultant or designee must sign and provide the child care center licensing fee invoice to the center.

d. Payment. The center must return the child care center licensing fee invoice to the department with the licensing fee payment within 60 calendar days from the date on the invoice. Regulatory fees are nonrefundable and nontransferable.

109.2(6) *Adverse actions.*

a. Notice of adverse actions for a denial, revocation, or suspension and the right to appeal the licensing decision will be given to applicants and licensees in accordance with 441—Chapter 2506 and 441—subrule 16.2(3).

b. A letter received by an owner or director of a licensed center initiating action to deny, suspend, or revoke the facility's license must be conspicuously posted at the main entrance to the facility. The letter will remain posted until resolution of the action to deny, suspend, or revoke the license. If the action to deny, suspend, or revoke is upheld, the center must return the license to the department.

c. If the center's license is denied, suspended, or revoked, the department will notify the parent, guardian, or legal custodian of each child for whom the facility provides child care.

d. The center must cooperate with the department in providing the names and addresses of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—109.3(237A) Inspection and evaluation. The department will conduct an unannounced on-site visit in order to make a licensing recommendation for all initial and renewal applications for licensure and will determine compliance with licensing standards imposed by licensing laws and these rules when a valid complaint is received.

109.3(1) At least one unannounced on-site visit will be conducted each calendar year.

109.3(2) After each visit and valid complaint, the department will document whether a center was in compliance with center licensing standards imposed by licensing laws and these rules.

109.3(3) The written documentation of the department's conclusion as to whether a center was in compliance with licensing standards for all licensing visits and valid complaints will be available to the public. However, the identity of the complainant will be withheld unless expressly waived by the complainant.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.4(237A) Administration.

109.4(1) *Required written policies.* The child care center owner, board or director shall:

a. Develop and implement policies for enrollment and discharge of children, field trips and noncenter activities, discipline/behavior, nutrition, health and safety policies and, if transporting children, transportation policy.

b. Develop a curriculum or program structure that uses developmentally appropriate practices and an activity program appropriate to the developmental level and needs of the children.

c. Develop and implement a written plan for staff orientation to the center's policies and to the provisions of this chapter.

d. Make available for review a copy of the center policies and programs to all staff at the time of employment and each parent at the time a child is admitted to the center. A copy of the fee policies and financial agreements shall be provided to each parent at the time a child is admitted to the center.

e. When serving children under the age of three, develop and implement a policy for responding to incidents of biting.

f. Develop and implement a policy to ensure that people do not have unauthorized access to children at the center.

g. Develop and implement a policy for protection of each child's confidentiality.

h. Develop and implement procedures for medical and dental emergencies, and ensure through orientation and training that all staff are knowledgeable of and able to implement the procedures.

109.4(2) *Required postings.* The following postings must be conspicuously posted in an area frequented by parents or the public:

a. Certificate of license at the main entrance of the center.

b. Notice of exposure of children to a communicable disease. The notice of exposure of children to a communicable disease will include the symptoms and the period of communicability.

c. Notice of decision to deny, suspend, or revoke the center's license or reduce the center's license to a provisional status, if applicable.

d. Mandatory reporter requirements.

e. Notice of availability of the handbook "Child Care Centers and Preschools Licensing Standards and Procedures (August 1, 2024)."

f. Name and contact information of the department's child care licensing consultant.

g. Program activities and menu.

109.4(3) *Mandatory reporters.* Methods of identifying and reporting suspected child abuse and neglect shall be discussed with all staff within 30 days of employment.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.5(237A) Parental participation. Parents must be afforded unlimited access to their children and to the provider caring for their children during the center's hours of operation or whenever their children are in the care of a provider unless parental contact is prohibited by court order. The provider will inform all parents of this policy in writing at the time the child is admitted to the center.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.6(237A) Personnel. The director of the center must develop policies for hiring and maintaining staff that demonstrate competence in working with children and that meet the following minimum requirements:

109.6(1) *Center director requirements.* Centers that have multiple sites must have a center director or on-site supervisor in each center. The center director is responsible for the overall functions of the center, including supervising staff, designing curriculum and program administration. The director must ensure services are provided for the children within the framework of the licensing requirements. The center director must have overall responsibility for carrying out the program and ensuring the safety and protection of the children. The following minimum qualifications must be submitted to the child care consultant for final approval prior to the start of employment. The center director:

a. Is at least 21 years of age.

b. Has obtained a high school diploma or passed a general education development test.

c. Has completed at least one course in business administration or 12 contact hours in administrative-related training related to personnel, supervision, recordkeeping, or budgeting, or has one year of administrative-related experience.

d. Has certification in pediatric cardiopulmonary resuscitation (CPR), pediatric first aid, and Iowa's training for the mandatory reporting of child abuse.

e. Has achieved a total of 100 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT-RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	25	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	60	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	45	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's or higher degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	25	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 100 points, a minimum of two categories must be used, no more than 75 points may be achieved in any one category, and at least 20 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category must have been taken within the past five years.

(3) For directors in centers predominantly serving children with special needs, the directors may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity must be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.6(2) *On-site supervisor.* The on-site supervisor is required to be present when the program has multiple sites or when a director is not routinely present for six hours daily. The center director must identify a person in charge during the on-site supervisor's absence. The on-site supervisor is responsible for the daily supervision of the center and must be on site daily either during the hours of operation that children are present or a minimum of six hours of the center's hours of operation. The following minimum qualifications will be submitted to the child care consultant for final approval prior to the start of employment. The on-site supervisor:

a. Is at least 18 years of age.

b. Has obtained a high school diploma or passed a general education development test.

c. Has certification in infant, child, and adult CPR; infant, child, and adult first aid; and Iowa's mandatory reporting of child abuse.

d. Has achieved a total of 75 points obtained through a combination of education, experience, and child development-related training as outlined in the chart and calculation described in subrule 109.6(1). A minimum of two categories must be used, no more than 50 points may be achieved in any one category, and at least 10 points must be obtained from the experience category.

109.6(3) *Volunteers.* A volunteer must be at least 16 years of age. All volunteers shall:

a. Sign a statement indicating whether or not they have one of the following:

(1) A conviction of any law in any state or any record of founded child abuse or dependent adult abuse in any state.

(2) A communicable disease or other health concern that could pose a threat to the health, safety, or well-being of the children.

b. Sign a statement indicating the volunteer has been informed of the volunteer's responsibilities as a mandatory reporter.

c. Undergo the record check process when any of the following criteria are met:

(1) The volunteer is included in meeting the required child-to-staff ratio;

(2) The volunteer has direct responsibility for a child or children; or

(3) The volunteer has access to a child or children with no other staff present.

d. Have on file at the facility a record containing the statements required in paragraphs 109.6(3)*"a"* and *"b"* and documentation of any record check process. The record must be maintained as required in paragraph 109.9(1)*"a."*

109.6(4) *Record checks.*

a. Criminal and child abuse record checks. Criminal and child abuse record checks shall be conducted for:

(1) Each owner, director, staff member, volunteer, or subcontracted staff person with direct responsibility for child care or with access to a child when the child is alone;

(2) Anyone living in the child care facility who is 14 years of age or older.

b. Authorization. A requesting entity shall request a record check evaluation prior to the employment of a person subject to record checks. The person subject to record checks shall complete the department's criminal history record check form and any other forms required by the department of public safety to authorize the release of records.

c. Iowa records checks. Checks and evaluations of Iowa child abuse and criminal records, including the sex offender registry, must be completed before the person's involvement with child care at the center. Iowa records checks must be repeated at a minimum of every two years and when the department or the center becomes aware of any possible transgressions. The department is not responsible for the cost of conducting the Iowa records check.

(1) The child care center may access the single-contact repository (SING) as necessary to conduct a criminal and child abuse record check of the person in Iowa. If the results of the check indicate a potential transgression, the center will send a copy of the results to the department for determination of whether or not the person may be involved with child care, regardless of the person's status with the center.

(2) Unless a record check has already been conducted in accordance with subparagraph 109.6(4)*"c"*(1), the department must conduct a criminal and child abuse record check in Iowa for a person who is subject to a record check. The department may access SING to conduct the record check. The department may also conduct dependent adult abuse, sex offender, and other public or civil offense record checks in Iowa for a person who is subject to a record check.

d. National criminal history checks. National criminal history checks based on fingerprints are required for all persons subject to record checks. The national criminal history check must be repeated for each person every four years and when the department or center becomes aware of any new transgressions committed by that person in another state. The department is not responsible for the cost of conducting the national criminal history check.

(1) The child care center is responsible for obtaining the fingerprints of all persons subject to record checks.

(2) If the results of the Iowa records checks do not warrant prohibition of the person's involvement with child care or otherwise present protective concerns, the person may be involved with child care on a provisional basis until the national criminal history check and evaluation have been completed.

(3) The child care center will provide fingerprints to the department of public safety prior to a person's involvement with child care at the center. The center will submit the fingerprints on forms or in a manner allowed by the department of public safety.

(4) Centers that are required to submit fingerprint-based checks of the FBI national criminal database to comply with federal regulations may seek a waiver to substitute that record check for the procedure required in this subrule. Requests for a waiver must be submitted on a form prescribed by the department to the address listed on the form.

(5) A center considering involvement of a person who has had a national criminal history check at another center may request information from that center. That center may provide that information in writing upon a center's request, using a form prescribed by the department. If the person being considered for employment has not had involvement with child care in the past six months, a new national criminal history check must be completed.

(6) If the results of the national criminal history check indicate that the person has committed a transgression, the center, if interested in continuing the person's involvement in child care, must send a copy of the results to the department for evaluation. The department will determine whether or not the person may be involved with child care.

e. Mandatory and mandatory time-limited prohibition. A person with any convictions or founded abuse reports as defined in Iowa Code section 237A.5(2)*"i"* is prohibited from involvement with child care.

f. Evaluation required. For all other transgressions, and as requested under paragraph 109.6(4)*"e,"* the department will notify the requesting entity that an evaluation shall be conducted to determine whether prohibition of the person's involvement with child care is warranted.

(1) The person with the transgression must complete the record check evaluation form. The requesting entity must provide the form and any other documents to the department within ten calendar days of the date on the form. The department will use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and the requesting entity to return this form by the specified date will result in denial or revocation of the license or denial of employment. The department will not process evaluations that are not signed by the person subject to an evaluation.

(2) The department may use information from the department's case records in performing the evaluation.

(3) The requesting entity may provide, or the department may request from the person subject to an evaluation or from the requesting entity, information to assist in performance of the evaluation.

(4) Any person or agency that might have pertinent information regarding criminal or abuse history and rehabilitation of the prospective employee may be contacted.

(5) In an evaluation, the department will consider all of the factors established in Iowa Code section 237A.5(2)*"h."*

(6) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the provisions established in Iowa Code section 237A.5(2)*"g."*

g. Evaluation decision. Within 30 days of receipt of a completed record check evaluation, the department will make a decision on the person's involvement with child care. The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements and corrective action plan under this paragraph.

(1) The department will mail to the requesting entity and the person on whom the evaluation was completed the record check decision that explains the decision reached regarding the evaluation of the transgression.

(2) If the department determines through an evaluation of a person's transgressions that the person's prohibition of involvement with child care is warranted, the person will be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(3) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions and corrective action plan relating to the person's involvement with child care.

(4) The department will send a letter to the employer that informs the employer whether the person subject to an evaluation has been approved or denied involvement with child care. If the person has been approved, the letter will inform the employer of any conditions and corrective action plan relating to the person's involvement with child care.

h. Notice to parents. The department will provide notification of founded child abuse committed by an owner, director, or staff member of the child care center pursuant to Iowa Code section 237A.5(2)*"k."* The center must cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

109.6(5) *Use of controlled substances and medications.* All owners, personnel, and volunteers must be free of the use of illegal drugs and not be under the influence of alcohol or of any prescription or nonprescription drug that could impair their ability to function.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.7(237A) Professional growth and development. Professional development will supplement the educational and experience requirements in rule 441—109.6(237A) and shall enhance the staff's skill in working with the developmental and cultural characteristics of the children served. The center director, on-site supervisor, and staff counted as part of the staff ratio must meet the following minimum staff training requirements:

109.7(1) *Required training within the first three months of employment.* During their first three months of employment, all staff must receive the following training:

a. Iowa's training for mandatory reporting of child abuse.

b. At least one hour of training regarding universal precautions.

c. Certification in infant, child, and adult CPR. A valid certificate indicating the date of training and expiration date will be maintained.

d. Certification in infant, child, and adult first aid. A valid certificate indicating the date of training and expiration date must be maintained.

e. Essential child care pre-service or equivalent minimum health and safety training approved by the department in the following areas:

(1) Prevention and control of infectious disease, including immunizations.

(2) Prevention of sudden infant death syndrome and use of safe sleep practices.

(3) Administration of medication, consistent with standards for parental consent.

(4) Prevention of and response to emergencies due to food and allergic reactions.

(5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.

(6) Prevention of shaken baby syndrome, abusive head trauma, and child maltreatment.

(7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.

(8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.

(9) Precautions in transporting children.

(10) Child development.

Essential child care pre-service or equivalent minimum health and safety training may be required if content has significant changes that warrant that the training be renewed.

Child care staff employed in programs that only serve children over the age of three are exempt from taking health and safety trainings under subparagraphs 109.7(1)*"e"*(2) and 109.7(1)*"e"*(6).

109.7(2) *Center directors and all staff.*

a. During their first year of employment, all center directors and all staff will receive the following training:

(1) Ten contact hours of training from approved subject areas from the Council for Professional Recognition or approved content areas from the National Afterschool Association.

(2) Training received for CPR, first aid, mandatory reporting of child abuse, and universal precautions shall not count toward the ten contact hours.

b. Following their first year of employment, all center directors and all staff must:

(1) Maintain current certification for Iowa's training for the mandatory reporting of child abuse; infant, child and adult CPR; and infant, child and adult first aid.

(2) Staff must receive six contact hours of professional development annually from one or more of the subject areas under subparagraph 109.7(2)*"a"*(1).

(3) Center directors and on-site supervisors must receive eight contact hours of training annually from one or more approved subject areas under subparagraph 109.7(2)*"a"*(1).

109.7(3) *Staff employed in centers that operate summer-only programs.* During their first three months of employment, all staff shall receive the following training:

a. Iowa's training for mandatory reporting of child abuse.

b. At least one hour of training regarding universal precautions.

c. Certification in infant, child, and adult CPR. A valid certificate indicating the date of training and expiration date shall be maintained.

d. Certification in infant, child, and adult first aid. A valid certificate indicating the date of training and expiration date shall be maintained.

e. Essential child care pre-service or equivalent minimum health and safety training approved by the department in the following areas:

(1) Prevention and control of infectious disease, including immunizations.

(2) Prevention of sudden infant death syndrome and use of safe sleep practices.

(3) Administration of medication, consistent with standards for parental consent.

(4) Prevention of and response to emergencies due to food and allergic reactions.

(5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.

(6) Prevention of shaken baby syndrome, abusive head trauma, and child maltreatment.

(7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.

(8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.

(9) Precautions in transporting children.

(10) Child development.

Child care staff employed in programs that only serve children over the age of three are exempt from taking health and safety trainings under subparagraphs 109.7(3)*"e"*(2) and 109.7(3)*"e"*(6).

109.7(4) *Substitution.* A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC) (August 1, 2024), or Early Childhood-Positive Behavior Interventions and Supports (EC-PBIS) training series (August 1, 2024) may use those hours to fulfill a maximum of two years' professional development requirements, not including preservice, first-aid, CPR and mandatory reporter training.

109.7(5) *Approved professional development.*

a. Professional development contact hours can be coaching, education, or training provided by a department-approved entity.

b. Coaching contact hours may only be used to meet up to half of an individual's annual professional development requirement.

c. The department may randomly monitor any state-approved professional development for quality control purposes.

d. Professional development conducted with staff during the hours of operation of the facility, during staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff must not be actively engaged in care and supervision and simultaneously participate in training.

e. A professional development organization not approved by the department may submit for review to the department a request for child care training approval. All approvals unless otherwise specified shall be valid for five years. The department will issue its decision within 30 business days of receipt of a complete request.

f. Department-approved entities must provide participants a professional development certificate for approved professional development contact hours.

109.7(6) *Professional development for supervisors and designees.* The director, on-site supervisor, and any person designated as a lead in the absence of supervisory staff must have completed all preservice/orientation training outlined in subrule 109.7(1).

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25; **ARC 0448D**, IAB 7/22/26, effective 9/1/26]

441—109.8(237A) Staff ratio requirements.

109.8(1) *Staff requirements.* Persons counted as part of the staff ratio must meet the following requirements:

a. Staff persons must be at least 16 years of age.

b. Those staff persons who are under the age of 18 shall meet the following requirements:

(1) May not be the sole provider on the premises of a child care facility.

(2) Shall not provide transportation to children in care.

(3) If staff persons under the age of 18 are providing child care services without an adult, they shall only provide care to school-aged children.

(4) May be utilized for brief periods of absence as identified in paragraph 109.8(2)*"g"* and scheduled nap periods of children over two years of age as identified in paragraph 109.8(2)*"h."*

109.8(2) *Staff ratio.* The staff-to-child ratio shall be as follows:

Age of children	Minimum ratio of staff to children
Two weeks to two years	One to every 4 children
Two years	One to every 7 children
Three years	One to every 10 children
Four years	One to every 12 children
Five years to ten years	One to every 15 children
Ten years and over	One to every 20 children

a. Combinations of age groupings for children four years of age and older may be allowed and may have staff ratio determined on the age of the majority of the children in the group.

b. Combinations of age groupings for children three, four, and five years of age may be allowed with a ratio of one staff member to every 12 children.

c. Children between 18 months and three years of age may be combined, if appropriate to the developmental needs of the child. If a child under two years of age is in a combined age group, the staff ratio of one to seven will be maintained. Otherwise, staff ratio may be determined by the age of the majority of the children in the group.

d. Combinations of age groupings that do not meet paragraphs 109.8(2)*"a"* through *"c"* may be approved by a child care licensing consultant when a program can show developmentally appropriate curriculum for all age groups and can provide sufficient supervision.

e. Combinations of age groupings for children five years of age and older must have a ratio consistent with the age of majority.

f. Upon the recommendation of a child's physician or the area education agency serving the child, a child who is two years of age or older with a disability that results in significant developmental delays in physical and cognitive functioning who does not pose a threat to the safety of the infants may, if appropriate and for a limited time approved by the department, remain in the infant area.

g. Every child-occupied program room must have supervision present in the room. Brief absences of a staff member may be allowed for no more than five minutes when another staff person is present.

h. During nap time, at least one staff member must be present in every room where children are resting. Staff ratio requirements may be reduced to one staff member per room where children are resting and staff ratio coverage can be maintained in the center. The staff ratio must always be maintained for children under two years of age.

i. When more than eight children are present on the licensed premises, at least two staff members shall be present.

j. For a period of two hours or less at the beginning and end of the center's hours of operation, one staff member may care for eight or fewer children, provided no more than four of the children are under two years of age and there are no more than eight children in the center.

k. When more than eight children are being transported in one vehicle, at least two staff members must be present, one of which is over 18 years of age.

(1) Only one adult is required when a center is transporting children in a center-owned vehicle with parent authorization for the sole purpose of transporting children to and from school.

(2) When a center contracts with another entity to provide transportation other than for the purpose of transporting children to or from school, at least one adult staff in addition to the driver must be present if at least eight children provided care by the center are transported.

l. Any child care center-sponsored program activity involving six or more children conducted away from the licensed facility shall provide a minimum of one additional staff over the required staff ratio for the protection of the children. At least one staff present on field trips must be over 18 years of age.

m. For centers serving school-age children, the ratio for school-age children may be exceeded for a period of no more than four hours during a day when school classes start late or are dismissed early or canceled due to inclement weather or structural damage provided the children are already enrolled at the center and the center does not exceed the licensed capacity.

109.8(3) *Group size.* Group size is determined in collaboration with the state fire marshal and will be assigned based on the review of health and safety requirements. Maximum capacity allowed shall be included on the certificate of license. Group sizes by age group must be included in annual inspection reports.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.9(237A) Records.

109.9(1) *Personnel records.* The center will maintain personnel information sufficient to ensure that persons employed in the center meet minimum staff and training requirements and do not pose any threat to the health, safety, or well-being of the children. Each employee's file must contain, at a minimum, the following:

a. Copies of all record checks kept in accordance with state and federal law regarding confidentiality of record checks. These records shall include:

(1) A copy of a department criminal history record check form or any other permission form approved by the department of public safety for conducting an Iowa or national criminal history record check.

(2) A copy of a request for child abuse information form, when applicable.

(3) Copies of the results of Iowa record checks conducted through the SING for review by the department upon request.

(4) Copies of national criminal history check results.

(5) Any department-issued documents sent to the center related to a record check, regardless of findings.

b. A physical examination report. As required in Iowa Code section 237A.5(1), personnel shall have good health as evidenced by a physical examination within six months of hire. Acceptable physical examinations shall be documented on a form prescribed by the department. The examination shall be performed within six months of beginning employment and shall be repeated at least every three years. A physical examination may be requested if the employer has reason to believe an employee would not be able to perform a job successfully or safely due to a medical condition.

c. Documentation showing the minimum staff training requirements as outlined in rule 441—109.7(237A) are met, including current certifications in first aid and CPR and Iowa's training for the mandatory reporting of child abuse.

d. A photocopy of a valid driver's license if the staff will be involved in the transportation of children.

109.9(2) *Child's file.* Centers must maintain current and sufficient information in a file for each child that includes:

a. Child enrollment information, including name, age, date of birth, and address.

b. Parent/guardian contact information.

c. Emergency contacts and persons who can pick up the child as authorized by the parent.

d. Contact information and authorization of emergency medical and dental services.

e. Health and medical needs of a child, including any allergies or special health needs, a written emergency plan and prescribed treatment.

f. Incident reports of injuries, accidents, or other incidents, as applicable.

g. Parent authorization for a child to attend center-sponsored field trips and noncenter activities.

h. Signed and dated valid Certificate of Immunization, Certificate of Immunization Exemption, or Provisional Certificate of Immunization, provided by the department must be on file for each child enrolled as required by 641—Chapter 7.

i. For each child not yet enrolled in kindergarten, the child care center must require a physical examination submitted at enrollment but no later than within four weeks of admission. The physical should include a health history and status of present health, including allergies, medications, acute or chronic conditions, and care plan when needed. The physical should be completed and signed by the child's primary health care provider (MD, DO, chiropractor, PA, or ARNP). The date of the physical examination shall be no more than 12 months prior to the first day of admission and annually thereafter until kindergarten entry.

j. For school-aged children, the child care center must have a statement of health signed by the parent indicating the child's health status, allergies, medications, acute or chronic conditions and care plan when needed.

k. For a child who has a special health need, there must be a written care plan completed and signed by the child's primary health care provider (MD, DO, chiropractor, PA, or ARNP) or parent or guardian. The care plan should include the care needed, when the care is to be given, and any possible complications or side effects, including required interventions. Documentation of special needs provided should be in a manner similar to documentation for medication administration.

109.9(3) *Daily activities.* For each child under two years of age, the center must make a daily written record. At the end of the child's day at the center, the daily written record shall be provided verbally or in writing to the parent or the person who removes the child from the center. The record shall contain information on each of these areas:

a. The time periods in which the child has slept.

b. The amount of food consumed and the times at which the child has eaten.

c. The time of and any irregularities in the child's elimination patterns.

d. The general disposition of the child.

e. A general summary of the activities in which the child participated.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25; **ARC 0448D**, IAB 7/22/26, effective 9/1/26]

441—109.10(237A) Health and safety policies. The child care center will establish definite health policies, including the criteria for excluding a sick child from a center. The child care center may be provided guidance from the child care center's child care nurse consultant or the department regarding exclusion of an exposed child or staff during a communicable disease outbreak.

109.10(1) *Medications.* The center shall have written procedures for the dispensing, storage, authorization, and recording of all prescription medications, nonprescription medications, and nonmedicated topical products, including the following:

a. Staff must be over 18 to administer medication.

b. All medications must be stored in their original containers, with accompanying physician or pharmacist's directions and label intact and stored so the medications are inaccessible to children and the public. Nonprescription medications must be labeled with the child's name.

c. For every day an authorization for medication is in effect and the child is in attendance, there shall be a notation of administration, including the name of the medicine, date, time, dosage given or applied, and the initials of the person administering the medication or the reason the medication was not given.

d. In the case of medications that are administered on an ongoing, long-term basis, authorization must be obtained for a period not to exceed the duration of the prescription.

e. A child care staff member shall not provide medications to a child if the staff member has not completed preservice/orientation training that includes medication administration.

109.10(2) *Daily contact.* Each child shall have direct contact with a staff person upon arrival for early detection of apparent illness, communicable disease, or unusual condition or behavior that may adversely affect the child or the group.

109.10(3) *Infectious disease control.* Centers must establish policies and procedures related to infectious disease control and the use of universal precautions with the handling of any bodily fluids that include blood, bodily excrement or discharge. Soiled diapers shall be stored in containers separate from other waste. Sanitation and safety procedures for the center are developed and implemented to reduce the risk of injury or harm to children and reduce the transmission of disease.

109.10(4) *Quiet area for ill or injured.* The center will provide a quiet area under supervision for a child who appears to be ill or injured. The parents or a designated person will be notified of the child's status in the event of a serious illness or emergency.

109.10(5) *Staff hand washing.* The center must ensure that staff demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease.

109.10(6) *Children's hand washing.* The center shall ensure that staff assist children in personal hygiene sufficient to prevent or minimize the transmission of illness or disease. For each infant or child with a disability, a separate cloth for washing, one for rinsing, and one for drying may be used in place of running water.

109.10(7) *First-aid kit.* The center must ensure that a clearly labeled first-aid kit is available and easily accessible to staff at all times whenever children are in the center, in the outdoor play area, and on field trips. The kit must be sufficient to address first aid related to minor injury or trauma and stored in an area inaccessible to children.

109.10(8) *Recording incidents.*

a. Incidents involving a child, including minor injuries, minor changes in health status, or other minor behavioral concerns, shall be reported to the parents, guardians, and legal custodians on the day of the incident.

b. Incidents resulting in a serious injury, as defined in Iowa Code section 702.18, to a child in the child care facility or in the care of child care facility staff or incidents resulting in a significant change in the health status of a child must be verbally reported to the parents, guardians, and legal custodians immediately.

(1) Serious injuries must be reported to the department within 24 hours of the incident.

(2) Serious injuries must be documented and information maintained in the child's file as required by subrule 109.9(2).

c. The parents, guardians, and legal custodians of any child included in incidents involving inappropriate, sexually acting-out behavior must be notified immediately after the incident. A written report fully documenting every incident will be provided to the parent or person authorized to remove the child from the center. The written report shall be prepared by the staff member who observed the incident, and a copy will be retained in the child's file.

109.10(9) *Smoking.* Smoking and the use of tobacco products must be prohibited and nonsmoking signs must be posted pursuant to Iowa Code chapter 142D.

109.10(10) *Transportation.* Children must be transported pursuant to Iowa Code section 321.446.

109.10(11) *Field trips.* Emergency telephone numbers and emergency health plans, as applicable, for each child must be taken by staff when transporting children to and from school and on field trips and non-center-sponsored activities away from the premises.

109.10(12) *Pets.* Animals kept on site must be in good health with no evidence of disease, be of such disposition as to not pose a safety threat to children, and be maintained in a clean and sanitary manner. Documentation of current vaccinations shall be available for all cats and dogs. No ferrets; reptiles, including turtles; or birds of the parrot family can be kept on site. Pets are not allowed in the kitchen or food preparation areas.

109.10(13) *Emergency plans.*

a. The center shall have written emergency plans and diagrams for responding to fire, tornado, and flood (if area is susceptible to flood) and plans for responding to intoxicated parents and lost or abducted children. Emergency plans must include written procedures, including plans for the following:

(1) Evacuation to safely leave the facility.

(2) Relocation to a common, safe location after evacuation.

(3) Shelter-in-place to take immediate shelter when the current location is unsafe to leave due to the emergency issue.

(4) Lockdown to protect children and providers from an external situation.

(5) Communication and reunification with parents or other adults responsible for the children that includes emergency telephone numbers.

(6) Continuity of operations.

(7) To address the needs of individual children, including those with functional or access needs.

b. Emergency instructions; telephone numbers; and diagrams for fire, tornado, and flood (if area is susceptible to floods) must be visibly posted by all program and outdoor exits. Emergency plan procedures must be practiced and documented at least once a month for fire and for tornado. Records on the practice of fire and tornado drills must be maintained for the current and previous year.

c. The center must develop procedures for annual staff and volunteer training on these emergency plans and include information on responding to fire, tornadoes, intruders, intoxicated parents, and lost or abducted children in the orientation provided to new employees and volunteers.

d. The center must conduct a daily check to ensure that all exits are unobstructed.

109.10(14) *Supervision and access.*

a. The center director and on-site supervisor must ensure that each staff member or volunteer knows the number and names of children assigned to that staff member or volunteer for care. Assigned staff and volunteers must provide careful supervision.

b. Any person in the center who is not an owner, staff member, or volunteer who has a record check and department approval to be involved with child care must not have unrestricted access to children for whom that person is not the parent, guardian, or custodian.

c. A parent who is a registered sex offender under Iowa Code chapter 692A cannot be present upon the property of a child care center except for the time reasonably necessary to transport the offender's own minor child or ward to and from the center. Under limited circumstances, a center director may give written permission to be on the property. Before giving written permission, the center director will consult with the center licensing consultant. The written permission must be signed and dated by the center director and the sex offender and kept on file for review by the center licensing consultant.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.11(237A) Physical facilities.

109.11(1) *Room size.* The program room size must be a minimum of 80 square feet of useable floor space or sufficient floor space to provide 35 square feet of useable floor space per child. In rooms where floor space occupied by cribs is counted as useable floor space, there must be 40 square feet of floor space per child. Kitchens, bathrooms, halls, lobby areas, storage areas and other areas of the center not designed as activity space for children cannot be used as regular program space or counted as useable floor space.

109.11(2) *Play equipment, materials and furniture.*

a. The center will provide sufficient and safe indoor play equipment, materials, and furniture that conform with the standards or recommendations of the Consumer Product Safety Commission (CPSC) (August 1, 2024) or the American Society for Testing and Materials (ASTM) (August 1, 2024) for juvenile products. Play equipment, materials, and furniture must meet the developmental, activity, and special needs of the children.

b. Rooms must be arranged so as not to obstruct the direct observation of children by staff. Individual covered mats, beds, or cots and appropriate bedding will be provided for all children who nap. The center will develop procedures to ensure that all equipment and materials are maintained in a sanitary manner. Sufficient spacing must be maintained. The center shall provide sufficient toilet articles for each child for hand washing.

109.11(3) *Indoor facility requirements.*

a. The center shall ensure that:

(1) The facility and premises are sanitary, safe and hazard-free.

(2) The facility has sufficient:

1. Lighting.
2. Ventilation.
3. Heating and cooling.

(3) Equipment placed in a program area is maintained so as not to result in injury to children.

109.11(4) *Outdoor facility requirements.*

a. Centers must have a safe outdoor program area adjacent to the center, with sufficient square footage to accommodate at least 30 percent of the enrollment capacity at any one time at 75 square feet per child. The outdoor area must:

(1) Be free from litter and unsafe materials and free from contamination by the drainage or ponding of sewage or storm water.

(2) Include safe play equipment and an area of shade.

(3) Include fencing to protect from bodies of water and vehicular traffic.

b. The director or designated person must complete and keep a record of at least monthly inspections of the outdoor play area and equipment for the purpose of assessing and rectifying potential safety hazards. If the outdoor play area is not used for a period of time due to inclement weather conditions, the center shall document the reasons why the monthly inspection did not occur and must complete and document an inspection prior to resuming use of the area.

c. Approval may be given by the department to waive the outdoor space requirement for programs of three hours or less, provided there is suitable substitute space and equipment available.

d. Approval may be given by the department for centers operating in a densely developed area to use alternative outdoor play areas in lieu of adjacent outdoor play areas.

109.11(5) *Bathroom facilities.* At least one functioning toilet and one sink per 15 children two years of age and older must be provided in a room with natural or artificial ventilation. New construction after November 1, 1995, must provide for at least one sink in the same area as the toilet and, for centers serving children two weeks to two years of age, shall provide for at least one sink in the central diapering area. At least one sink must be provided in program rooms for infants and toddlers or in an adjacent area other than the kitchen. New construction after April 1, 1998, shall have at least one sink provided in the program rooms for infants and toddlers.

109.11(6) *Telephone.* A working nonpay telephone must be available in the center with emergency telephone numbers for police or 911, fire, ambulance, and poison control center posted in a conspicuous area. The street address and telephone number of the center must be included in the posting. A separate file or listing of emergency telephone numbers for each child shall be maintained.

109.11(7) *Kitchen appliances.* Gas or electric ranges or ovens shall not be placed in the program area. If kitchen appliances are maintained in the program area for food preparation activities, the area must be sectioned off and shall not be counted as useable floor space for room size.

109.11(8) *Environmental hazards.*

a. Within one year of being issued an initial or renewal license, centers operating in facilities built prior to 1978 shall conduct a visual assessment for lead hazards that exist in the form of peeling, cracking or chipping paint or painted surfaces in need of repair. If these lead hazards are found, it shall be assumed that lead-based paint is present on the surfaces, and the surfaces shall be repaired by an Iowa certified lead-safe renovator before a full license will be issued.

b. Within one year of being issued an initial or renewal license, centers operating in facilities that are at ground level, use a basement area as program space, or have a basement beneath the program area shall have radon testing following the National Consensus Standards as outlined in 641—Chapter 43.

c. To reduce the risk of carbon monoxide poisoning, all centers shall, on an annual basis, have a professional inspect all fuel-burning appliances, including oil and gas furnaces, gas water heaters, gas ranges and ovens, and gas dryers, to ensure the appliances are in good working order with proper ventilation. All centers shall install one carbon monoxide detector on each floor of the center that is listed with Underwriters Laboratory (UL) as conforming to UL Standard 2034 (August 7, 2024).

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.12(237A) Activity program requirements.

109.12(1) *Activities.* The center shall have a written curriculum that uses developmentally appropriate practices and a written program of activities planned according to the developmental level of the children. The center shall post a schedule of the program in a visible place. The child care program shall complement but not duplicate the school curriculum. The program shall be designed to provide children with:

a. A curriculum or program of activities that supports development of self-esteem, self-regulation, positive social interactions, communication skills, curiosity, problem-solving, creative expression, and gross motor and fine motor development.

b. A balance of active and quiet activities, individual and group activities, indoor and outdoor activities, and staff-initiated and child-initiated activities.

c. Experiences in harmony with the ethnic and cultural backgrounds of the children.

d. A supervised nap or quiet time for all children under six years of age not enrolled in school who are present at the center for five or more hours.

109.12(2) *Discipline.* The center shall have a written policy that shall be provided to staff at the start of employment and to parents at the time of admission. The center shall not use as a form of discipline:

a. Corporal punishment, including spanking, shaking, and slapping.

b. Punishment that is humiliating or frightening or that causes pain to the child. Children shall never be locked in a room or closet.

c. When restraints are part of a treatment plan for a child with a disability authorized by the parent and a psychologist or psychiatrist, staff shall receive training on the safe and appropriate use of the restraint.

d. Punishment or threat of punishment associated with a child's illness, lack of progress in toilet training, or in connection with food or rest.

e. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

109.12(3) *Children requiring special accommodations.* Reasonable accommodations, based on the special needs of the child, must be made in providing care to a child with a disability.

109.12(4) *Infant environment.*

a. An area shall be provided that is properly and safely equipped for the use of infants and free from the intrusion of children two years of age and older.

b. Each infant and toddler shall be diapered in a sanitary manner as frequently as needed at a central diapering area. Diapering, sanitation, and hand-washing procedures shall be posted and implemented in every diapering area. There shall be at least one changing table for every 15 infants.

c. Highchairs or hook-on seats shall be equipped with a safety strap that shall be engaged when the chair is in use and shall be constructed so the chair will not topple.

d. Safe, washable toys, large enough so they cannot be swallowed and with no removable parts, shall be provided. All hard-surface toys used by children shall be sanitized daily.

e. The provider shall follow safe sleep practices for infants under one year of age.

(1) Infants shall always be placed on their backs for sleep.

(2) Infants shall be placed on a firm mattress with a tight fitted sheet that meets U.S. Consumer Product Safety Commission (August 1, 2024) and ASTM federal standards (August 1, 2024).

(3) Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child shall be allowed to sleep in any item not designed for infant sleeping, including but not limited to an infant seat, car seat, swing, or bouncy seat.

(4) No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

(5) No co-sleeping shall be allowed.

(6) Sleeping infants shall be actively observed by sight and sound.

(7) If an alternate sleeping position is needed, a signed physician or physician associate authorization with statement of medical reason is required and an expiration date.

f. A crib or crib-like furniture that has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and that meets the current standards or recommendations from the U.S.

Consumer Product Safety Commission (August 1, 2024) or ASTM International (August 1, 2024) for juvenile products shall be provided for each child under two years of age if developmentally appropriate. Crib railings shall be fully raised and secured when the child is in the crib. A crib or crib-like furniture shall be provided for the number of children present at any one time. The center shall develop procedures for maintaining all cribs or crib-like furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

g. Infant walkers cannot be used.

h. All items used for sleeping must be used in compliance with manufacturer standards for age and weight of the child.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—109.13(237A) Food services. Centers participating in the USDA Child and Adult Care Food Program (CACFP) may have requirements that differ from those outlined in this rule in obtaining CACFP reimbursement and shall consult with a state CACFP consultant.

109.13(1) *Nutritionally balanced meals or snacks.* The center shall serve each child a full, nutritionally balanced meal or snack as defined by the CACFP guidelines (August 1, 2024) and shall ensure that staff provide supervision at the table during snacks and meals. Children remaining at the center two hours or longer shall be offered food at intervals of not less than two hours or more than three hours apart unless the child is asleep.

109.13(2) *Menu planning.* The center shall follow the minimum CACFP menu patterns for meals and snacks and serving sizes for children aged infant to 13 years (August 1, 2024). Menus shall be made available to parents and kept on file at the center. Substitutions in the menu, including substitutions made for infants, shall be noted and kept on file. Foods with a high incident rate of causing choking in young children should not be served per CACFP FNS-877 (August 1, 2024). Exceptions shall be allowed for special diets because of medical reasons in accordance with the child's needs and written instructions of a licensed physician or health care provider.

109.13(3) *Feeding of children under two years of age.*

a. All children under 12 months of age shall be fed on demand unless the parent provides other written instructions. Meals and snacks provided by the center shall follow the CACFP infant menu patterns (August 1, 2024). Foods shall be appropriate for the infant's nutritional requirements and eating abilities. Special formulas prescribed by a physician or health care provider shall be given to a child who has a feeding problem.

b. Bottles or containers of infant foods should be warmed under running, warm tap water or by placing them in a container of water that is no warmer than 120°F (49°C). Bottles and infant foods should never be warmed in a microwave oven.

c. All children under six months of age shall be held or placed in a sitting-up position sufficient to prevent aspiration during feeding. No bottles shall be propped for children of any age. A child shall not be placed in a crib or cot with a bottle or any other food item or left sleeping with a bottle or food item. Spoon feeding shall be adapted to the developmental capabilities of the child.

d. Single-service, ready-to-feed formulas, concentrated or powdered formula following the manufacturer's instructions or breast milk shall be used for children 12 months of age and younger unless otherwise ordered by a parent or physician.

e. Whole milk for children under two years of age who are not on formula or breast milk unless otherwise directed by a physician shall be used.

f. Cleaned and sanitized bottles and nipples shall be used for bottles prepared on site. Prepared bottles shall be kept under refrigeration when not in use.

109.13(4) *Food brought from home.*

a. The center shall establish policies regarding food brought from home for children under five years of age who are not enrolled in school. A copy of the written policy shall be given to the parent at admission. Food brought from home for children under five years of age who are not enrolled in school shall be monitored and supplemented if necessary to ensure CACFP guidelines (August 1, 2024) are maintained.

b. The center may not restrict a parent from providing meals brought from home for school-age children or apply nutritional standards to the meals.

c. Perishable foods brought from home shall be maintained to avoid contamination or spoilage.

d. Snacks that may not meet CACFP nutrition guidelines (August 1, 2024) may be provided by parents for special occasions such as birthdays or holidays.

109.13(5) *Food preparation, storage, and sanitation.* Centers shall ensure that food preparation and storage procedures are consistent with the recommendations of the CACFPs (August 1, 2024) and provide:

a. Sufficient refrigeration appropriate to the perishable food to prevent spoilage or the growth of bacteria.

b. Sanitary and safe methods in food preparation, serving, and storage sufficient to prevent the transmission of disease, infestation of insects and rodents, and the spoilage of food. Staff preparing food who have injuries on their hands shall wear protective gloves. Staff serving food shall have clean hands or wear protective gloves and use clean serving utensils.

c. Sanitary methods for dish-washing techniques sufficient to prevent the transmission of disease.

d. Sanitary methods for garbage disposal sufficient to prevent the transmission of disease and infestation of insects and rodents.

109.13(6) *Water supply.* The center shall ensure that suitable water and sanitary drinking facilities are available and accessible to children. Centers that serve infants and toddlers shall provide individual cups for drinking in addition to drinking fountains that may be available in the center.

a. Private water supplies shall be of satisfactory bacteriological quality as shown by an annual laboratory analysis. Water for the analysis shall be drawn between May 1 and June 30 of each year. When the center provides care for children under two years of age, a nitrate analysis shall also be obtained.

b. When public or private water supplies are determined unsuitable for drinking, commercially bottled water certified as chemically and bacteriologically potable or water treated through a process approved by the health department or designee shall be provided.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.14(237A) Extended evening care. A center providing extended evening care between the hours of 9 p.m. and 5 a.m. shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter, with the additional requirements set forth below.

109.14(1) *Facility requirements.*

a. The center shall ensure that sufficient cribs, beds, cots and bedding are provided appropriate to the child's age and that sufficient furniture, lighting, and activity materials are available for the children. Equipment and materials shall be maintained in a safe and sanitary manner.

b. The center shall ensure that a separate space is maintained for school-age boys and girls to provide privacy during bathroom and bedtime activities. Bathroom doors used by children shall be nonlockable.

c. The center shall ensure that parents have provided the personal effects needed to meet their child's personal hygiene and prepare for sleep. The center shall supplement those items needed for personal hygiene that the parent does not provide. The center shall obtain written information from the parent regarding the child's snacking, toileting, personal hygiene and bedtime routines.

109.14(2) *Activities.*

a. Evening activities shall be primarily self-selected by the child.

b. Every child-occupied room except those rooms used only by school-age children for sleeping shall have adult supervision present in the room. Staff counted for purposes of meeting child-to-staff ratios shall be present and awake at all times. In rooms where only school-age children are sleeping, visual monitoring equipment may be used. If a visual monitor is used, the monitoring must allow for all children to be visible at all times. Staff shall be present in the room with the monitor and shall enter the room used for sleeping to conduct a check of the children every 15 minutes.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.15(237A) School-based before- and after-school and summer programs. A building owned or leased by a school district or accredited nonpublic school that complies with rules adopted by the state fire marshal for school buildings is considered appropriate for use by a child care facility. Centers that

operate in a school building shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the following considerations:

109.15(1) Infant-specific regulations outlined in paragraph 109.12(4)*"e"* and subrule 109.13(3) are not applicable.

109.15(2) Centers may receive limited exemption from a facility requirement at subrule 109.11(3), particularly relating to ventilation and bathroom facilities, if complying with the requirement would require a structural or mechanical change to the school building.

109.15(3) Centers shall ensure that the indoor and outdoor space occupied by the center is sanitary, safe, and hazard-free. Outdoor space used for recreation during the school day is sufficient for use by the child care program.

109.15(4) Centers that serve only school-age children and that operate in a school building are exempted from testing for lead and carbon monoxide.

109.15(5) Personnel. For director requirements set forth in subrule 109.6(1), for centers serving predominantly school-age children, the directors may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

109.15(6) Child's file. All requirements under subrule 109.9(2) must be followed. For a center serving school-age children that operates in the same school facility in which the child attends school, documentation, including certificates of immunization, certificates of immunization exemption, or provisional certificates of immunization, shall be submitted to both locations in accordance with 641—Chapter 7.

[**ARC 9021C**, IAB 3/19/25, effective 7/1/25]

441—109.16(237A) Get-well center. A get-well center shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the additional requirements and exceptions set forth below.

109.16(1) *Staff requirements.*

a. The center shall have a medical advisor for the center's health policy. The medical advisor shall be a medical doctor or a doctor of osteopathy currently in pediatrics or family practice.

b. A center shall have a licensed LPN or RN on duty at all times that children are present. If the nurse on duty is an LPN, the medical advisor or an RN shall be available in the proximate area as defined in rule 655—6.3(152).

109.16(2) *Health policies.*

a. The center shall have a written health policy, consistent with the National Health and Safety Performance Standards (August 1, 2024), approved and signed by the owner or the chair of the board and by the medical advisor before the center can begin operations. Changes in the health policy shall be approved by the medical advisor and submitted in writing to the department. A written summary of the health policy shall be given to the parent when a child is enrolled in the center. The center's health policy at a minimum shall address procedures in the following areas:

(1) Medical consultation, medical emergencies, triage policies, storage and administration of medications, dietary considerations, sanitation and infection control, categorization of illness, length of enrollment periods, exclusion policy, and employee health policy.

(2) Reportable disease policies as required by the department.

b. The child shall be given a brief evaluation by an LPN or RN upon each arrival at the center.

c. The parent shall receive a brief written summary when the child is picked up at the end of the day. The summary must include:

(1) Admitting symptoms.

(2) Medications administered and time they were administered.

(3) Nutritional intake.

(4) Rest periods.

(5) Output.

(6) Temperature.

109.16(3) *Exceptions.* The following exceptions to this chapter shall be applied to get-well centers:

a. A center shall maintain a minimum staff ratio of one-to-four for infants and one-to-five for children over two years of age.

b. All staff who have contact with children shall have a minimum of ten clock hours of special training in caring for mildly ill children.

c. There shall be 40 square feet of program space per child.

d. Outdoor space may be waived with the approval of the department if the program is in an area adjacent to the pediatrics unit of a hospital.

e. Grouping of children shall be allowed by categorization of illness or by transmission route without regard to age and shall be in separate rooms with full walls and doors.

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These rules are intended to implement Iowa Code section 232.69 and chapter 237A.

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CHAPTER 110
CHILD DEVELOPMENT HOMES AND CHILD CARE HOMES WITH A CHILD CARE ASSISTANCE PROVIDER AGREEMENT

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/32

441—110.1(237A) Definitions.

"Adult" means a person 18 years of age or older.

"Assistant" means a responsible person 14 years of age or older employed by the child care provider. The assistant may never be left alone with children. Ultimate responsibility for supervision is with the child care provider.

"Category," when referring to category A, B, or C, means one of the three categories of standards for child development homes established by Iowa Code section 237A.3A(3)*"a."*

"Child" means the same as defined in Iowa Code section 237A.1.

"Child care" means the same as defined in Iowa Code section 237A.1.

"Child care assistance provider agreement" means the approved form to receive payment under the child care assistance program.

"Child care facility" or *"facility"* means the same as defined in Iowa Code section 237A.1.

"Child care home" means the same as defined in Iowa Code section 237A.1.

"Child development home" means the same as defined in Iowa Code section 237A.1.

"Child support services" means the same as defined in Iowa Code section 252J.1(2).

"Coaching" means a relationship-based process led by an expert to build capacity for specific professional dispositions, skills, and behaviors and is focused on performance-based outcomes.

"Education" means formal coursework offered through a state-approved accredited secondary school, college, or university.

"Infant" means the same as defined in Iowa Code section 237A.1.

"Involvement with child care" means the same as defined in Iowa Code section 237A.1.

"Nonregistered child care home" means a child care home that has an approved payment application and a current child care assistance provider agreement with the department. Nonregistered child care homes are required to meet minimum health and safety standards under the child care and development block grant under 45 CFR 98.41 as amended to August 1, 2026.

"Parent" means parent or legal guardian.

"Person subject to an evaluation" means the same as defined in Iowa Code section 237A.5.

"Professional development" means a continuum of learning activities designed to prepare and support individuals for work with children and families, including coaching, education, and training.

"Provider" means the person or program that applies for registration to provide child care and is approved as a child development home or a nonregistered child care home.

"Registration" means the process by which child care providers certify that they comply with rules adopted by the department.

"Registration certificate" means the written document issued by the department to publicly state that the provider has certified in writing compliance with the minimum requirements for registration of a child development home.

"Relative" means grandparents, great-grandparents, aunts, uncles, and siblings living in a separate residence.

"School" means the same as defined in Iowa Code section 237A.1.

"Training" means a learning experience that addresses a specific topic of professional relevance that builds or enhances knowledge.

"Transgression" means the same as defined in Iowa Code section 237A.1.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.2(237A) Application for registration as a child development home or payment as a nonregistered child care home.

110.2(1) A child development home provider shall apply for registration on the Application for Child Development Home Registration form.

110.2(2) A nonregistered provider shall apply for payment as a nonregistered child care home on the Payment Application for Nonregistered Provider form.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.3(237A) Renewal of registration or payment application. Renewal of registration or payment application shall be completed every 24 months. To request renewal, a provider shall submit a renewal application on the department-approved form and supply to the department all training completion evidence either through certificates or as updated in Iowa's early childhood and school age professional workforce registry (i-PoWeR).

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.4(237A) Compliance checks. Prior to child development home registration, a site visit to inspect for compliance with health, safety, and fire standards will be completed. An unannounced compliance visit will be conducted not less than annually to each child development home and nonregistered child care home.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.5(237A) Parental access. Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child development home or nonregistered child care home unless parental contact is prohibited by court order.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.6(237A) Number of children.

110.6(1) *Standards.* The number of children in a child development home or nonregistered child care home shall conform to the following standards.

a. Registered child development home limits. Except as provided in subrule 110.6(3), no greater number of children shall be received for care at any one time than the number authorized on the registration certificate.

b. Nonregistered child care home limits. No more than six children shall receive care at any one time if at least one child is school-aged.

110.6(2) *Children counted.* The number of children counted is as stated in Iowa Code section 237A.3A(4).

110.6(3) *Exception for emergency school closing.* On days when schools start late, are dismissed early, or are canceled or closed due to emergencies such as inclement weather, physical plant failure, structural damage, or public health emergency, a child development home may have additional children present in accordance with the authorization for the registration category of the home and subject to all of the following conditions:

a. One or more of the following conditions are applicable to each of the additional children present in the child development home:

(1) The home provides care to the child on a regular basis for periods of less than two hours.

(2) If the child were not present in the child development home, the child would be unattended.

(3) The home regularly provides care to a sibling of the child.

b. The provider shall maintain a written record, including the date of the emergency school closing, the reason for the closing, and the number of children in care on that date.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.7(237A) Provider requirements.

110.7(1) *Provider.* The provider shall:

a. Give careful supervision at all times.

b. Exchange information with the parent of each child frequently to enhance the quality of care.

c. Give consistent, dependable care and be capable of handling emergencies.

d. Be present at all times, except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute as permitted for a child development home under subrule 110.7(2).

e. Be free of the use of illegal drugs and not under the influence of alcohol or any prescription or nonprescription drug that could impair the provider's ability to give careful supervision.

110.7(2) *Substitutes in child development homes.* Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

a. All standards in this chapter regarding supervision and care of children shall apply to substitutes.

b. Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.

c. The substitute must be 18 years of age or older.

d. Use of a substitute shall be limited to:

(1) No more than 25 hours per month.

(2) An additional period of up to two weeks in a 12-month period.

e. The provider shall maintain a written record of the number of hours care is provided by a substitute, including the date of the care and the name of the substitute.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.8(237A) Standards. Conditions in the home shall be safe, sanitary, and free of hazards.

110.8(1) *Facility requirements.*

a. The home shall have a telephone with emergency numbers for police, fire, ambulance, and the poison information center accessible.

b. The phone number for each child's parent, and for a responsible person who can be reached when the parent is not available, shall be accessible.

c. All travel vehicles must have a copy of emergency parent contact information in the vehicle.

d. Electrical wiring shall be maintained, and all accessible electrical outlets shall be tamper-resistant outlets or shall be safely capped. Electrical cords shall be properly used and in the manner for which they were designed.

e. Combustible materials shall be kept a minimum of three feet away from furnaces, stoves, water heaters, and gas dryers.

f. Approved safety gates at stairways and doors shall be provided and used as needed.

g. Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the department shall be provided.

h. A safety barrier shall surround any heating stove or heating element.

i. The home shall have at least one 2A 10BC-rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

j. The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

k. Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. "No smoking" signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

(1) The telephone number for reporting complaints, and

(2) The internet address of the department where complaints can be filed.

l. Homes served by a private sewage disposal system shall be operated and maintained to ensure the system is properly treating the wastewater and not creating an unsanitary condition in the environment. Discharge of untreated wastewater from private sewage disposal systems is prohibited.

m. A provider operating in a facility built before 1978 shall assess and control lead hazards. To comply with this provision, the provider shall:

(1) Determine whether painted surfaces on the interior or exterior of the facility are chipping, peeling, cracking, or in need of repair. Painted surfaces include walls, ceilings, windows, doors, stairs, and woodwork; and

(2) If painted surfaces are in need of repair, the home shall hire an Iowa certified lead-safe renovator to make repairs. Iowa lead-safe renovators shall apply interim controls on any chipping, peeling, or cracking paint found, using lead-safe work methods in accordance with and as defined by department as set forth in 481—Chapters 469 and 470.

n. The child development home or nonregistered child care home shall be located in a single-family residence that is owned, rented, or leased by the person or, for dual registrations, at least one of the persons named on the child development home's certificate of registration.

o. Any driver who transports children for any purpose shall have a valid driver's license and adequate motor vehicle insurance that authorizes the driver to operate the type of vehicle being driven. Child restraint devices shall be utilized in compliance with Iowa Code section 321.446.

p. Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian. Veterinary examinations shall be documented on a veterinary health certificate or record of standard veterinary preventative care. This examination shall verify the animal's routine immunizations are current and there is no evidence of endoparasites and ectoparasites.

(2) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(3) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children cannot perform any feeding or care of pets or cleanup of pet waste.

(4) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

q. Using an injury report form, the provider shall document all injuries needing first aid or medical care. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

r. The provider shall have written policies regarding the care of mildly ill children and the exclusion of children due to illness and shall inform parents of these policies.

s. The provider shall have written policy and procedures for responding to health-related emergencies.

t. The certificate of registration shall be displayed in a conspicuous place.

u. Serious injuries, as defined in Iowa Code section 702.18, that occur in a child care facility or when a child is in the care of child care facility staff shall be reported to the department within 24 hours of the incident. Serious injuries shall be documented and information maintained in the child's file.

110.8(2) *Use of outdoor space.*

a. A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall:

(1) Be fenced off when located on a busy thoroughfare or near a hazard that could be injurious to a child.

(2) Have both sunshine and shade areas.

(3) Be kept free from litter, rubbish, and flammable materials.

(4) Be free from contamination by the drainage or ponding of sewage, household waste, or storm water.

b. When there is a swimming or wading pool on the premises:

(1) The wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the standards set forth by ASTM International intended to reduce the risk of drowning by inhibiting access to the water by children under five years of age.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high.

(4) An uncovered in-ground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high and flush with the ground.

c. If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation (CPR) for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

110.8(3) *Medications and hazardous materials.*

a. All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

b. A first aid kit shall be available and easily accessible whenever children are in the child development home or nonregistered child care home, in the outdoor play area, in vehicles used to transport children, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children. The kit shall at a minimum include adhesive bandages, bottled water, tweezers, and disposable plastic gloves.

c. Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, stored in a separate, covered container to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children. Any medication administered to a child shall be recorded, including the name of the medication, the date and time of administration, and the amount administered.

d. The provider shall establish procedures related to infectious disease control and handling of any bodily excrement or discharge or blood. Soiled diapers shall be stored in containers separate from other waste.

110.8(4) *Emergency plans.* Emergency plans in case of human-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

a. Fire and tornado drills shall be practiced monthly, and the provider shall keep documentation evidencing compliance with monthly practice on file for the current year and the previous year.

b. The provider must have procedures in place for the following:

(1) Evacuation to safely leave the facility.

(2) Relocation to a common, safe location after evacuation.

(3) Shelter-in-place to take immediate shelter where the child is when it is unsafe to leave that location due to the emergent issue.

(4) Lockdown to protect children and providers from an external situation.

(5) Communication and plans for reunification with families.

(6) Continuity of operations.

(7) To address the needs of individual children, including those with functional or physical access needs.

110.8(5) *Safe sleep.*

a. The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Infant sleep shall conform to the following standards:

(1) Infants shall always be placed on their backs for sleep.

(2) Infants shall be placed on a firm mattress with a tight-fitted sheet that meets U.S. Consumer Product Safety Commission standards.

(3) Infants cannot be allowed to sleep on a bed, sofa, air mattress, or other soft surface.

(4) No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

(5) No co-sleeping shall be allowed.

(6) Sleeping infants shall be actively observed by sight and sound.

(7) If an alternate sleeping position is needed, a signed physician or physician associate authorization with statement of medical reason is required.

b. No child shall be allowed to sleep in any item not designed for sleeping, such as an infant seat, car seat, swing, or bouncy seat.

c. A crib or criblike furniture that has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and that meets the current standards or recommendations from the U.S. Consumer Product Safety Commission or ASTM International for juvenile products shall be provided for each child under two years of age if developmentally appropriate. Crib railings shall be fully raised and secured when the child is in the crib. A crib or criblike furniture shall be provided for the number of children present at any one time. The home shall maintain all cribs or criblike furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

d. All items used for sleeping must be used in compliance with manufacturer standards for the age and weight of the child.

110.8(6) *Discipline.* Discipline shall conform to the following standards:

a. Corporal punishment, including spanking, shaking, and slapping, shall not be used.

b. Punishment that is humiliating or frightening or that causes pain or discomfort to the child shall not be used.

c. Punishment cannot be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated with food or rest.

d. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

e. Discipline shall emphasize prevention by having clear and consistent rules and by teaching children self-control, self-esteem, and respect for the rights of others.

110.8(7) *Meals and snacks.*

a. Registered child development homes shall provide regular meals, midmorning snacks, and midafternoon snacks.

(1) The meals and snacks shall be well-balanced, nourishing, and in appropriate amounts as defined by the United States Department of Agriculture (USDA) Child and Adult Care Food Program.

(2) Nonregistered child care homes do not have to meet the USDA Child and Adult Care Food Program.

b. Children may bring food to the child development home or nonregistered child care home for their own consumption but cannot be required to provide their own food.

c. Clean, sanitary drinking water shall be readily available to children in indoor and outdoor areas throughout the day.

110.8(8) *Activity program.* There shall be an activity program that promotes self-esteem and exploration and includes:

a. Active play.

b. Quiet play.

c. Activities for large-muscle development.

d. Activities for small-muscle development.

e. Play equipment and materials in a safe condition, for both indoor and outdoor activities that are developmentally appropriate for the ages and number of children present.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.9(237A) Files.

110.9(1) The child development home provider shall maintain a file that contains the following:

a. A physical examination report within six months of becoming registered. Acceptable physical examinations shall be documented on the Child Care Provider Physical Examination Report form. All children residing in the household must have the medical documentation outlined in paragraphs 110.9(4)*"d," "f,"* and *"g."*

b. i-PoWeR records or certificates verifying required training completion.

110.9(2) An individual file for each staff assistant in a child development home shall be maintained and contain the following:

a. Documentation from the department that confirms the required record checks have been completed and authorizes or conditionally limits the person's involvement with child care.

b. A completed Child Care Provider Physical Examination Report form.

c. Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69.

110.9(3) An individual file for each substitute in a child development home shall be maintained and shall contain the following:

a. Documentation from the department that confirms the required record checks have been completed and authorizes or conditionally limits the person's involvement with child care.

b. A completed Child Care Provider Physical Examination Report form.

c. Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69.

d. Certification in first aid and CPR.

e. Certification or other documentation that minimum health and safety training has been completed.

110.9(4) Children's files. An individual file for each child shall be maintained and updated annually or when the provider becomes aware of changes. If the child meets the definition of homelessness as defined by Section 725(2) of the McKinney-Vento Homeless Education Assistance Act as amended to August 1, 2026, the family shall receive a 60-day grace period to obtain medical documentation. The file shall contain:

a. Identifying information including at a minimum the child's name, birth date, and address.

b. Parent/guardian contact information.

c. Emergency contacts and persons who can pick up the child as authorized by the parent.

d. Contact information and authorization of emergency medical and dental services.

e. An admission physical examination report signed by a licensed medical doctor, doctor of osteopathy, chiropractor, physician associate, or advanced registered nurse practitioner.

(1) The date of the physical examination cannot be more than 12 months before the child's first day of attendance at the child development home or non-regulated child care home.

(2) The written report shall include the child's past health history; status of the child's present health, allergies, and restrictive conditions; and recommendations for continued care when necessary.

(3) For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physical examination report.

(4) The examination report or statement of health status shall be on file before the child's first day of care.

f. For children under the age of six, a statement of health condition signed by a licensed medical doctor, doctor of osteopathy, chiropractor, physician associate, or advanced registered nurse practitioner and submitted annually from the date of the admission physical examination. For a child who is enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the statement of health.

g. For each school-age child, on the first day of attendance, documentation of a physical examination that was completed at the time of school enrollment or since.

h. A signed and dated immunization certificate provided by the department. For the school-age child, a copy of the most recent immunization record shall be acceptable. Documentation of a valid certificate

of immunization exemption (religious or medical) or provisional certificate of immunization may be submitted in lieu of a certificate of immunization.

i. For any child with allergies, a written emergency care plan in case of an allergic reaction. A copy of this information shall accompany the child if the child leaves the premises.

j. Documentation that is signed by the parent and names of persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.

k. Written permission from the parent for the child to attend activities away from the child development home or nonregistered child care home.

l. Injury report forms documenting injuries requiring first aid or medical care.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.10(237A) Professional development.

110.10(1) *Required training.*

a. Prior to registration or approval as a nonregistered child care home, the provider shall complete minimum health and safety trainings, approved by the department, in all of the following areas:

(1) Prevention and control of infectious disease, including immunizations.

(2) Prevention of sudden infant death syndrome and use of safe sleep practices.

(3) Administration of medication, consistent with standards for parental consent.

(4) Prevention of and response to emergencies due to food and allergic reactions.

(5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.

(6) Prevention of shaken baby syndrome and abusive head trauma.

(7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.

(8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.

(9) Precautions in transporting children.

(10) Child development.

b. Prior to registration or approval as a nonregistered child care home, the provider shall complete two hours of Iowa's training for mandatory reporting of child abuse as required by Iowa Code section 232.69. The provider shall maintain a valid certificate indicating expiration date.

c. Prior to registration or approval as a nonregistered child care home, the provider shall complete pediatric first aid and pediatric CPR training that meets the following requirements:

(1) Training shall be provided by a nationally-recognized training organization, such as the American Red Cross, American Heart Association, National Safety Council, Health and Safety Institute (HSI), or by an equivalent trainer using curriculum approved by the department.

(2) The provider shall maintain a valid certificate indicating the date of first aid training and the expiration date.

(3) The provider shall maintain a valid certificate indicating the date of CPR training and the expiration date.

d. The provider must earn 12 contact hours of training each calendar year from approved subject areas from the Council for Professional Recognition or approved content areas from the National Afterschool Association.

e. During each calendar year, the nonregistered child care home provider shall receive a minimum of three hours of training from approved content areas. If course content overlaps between calendar years, hours may still count toward professional development requirements.

f. Minimum health and safety training may be required if content has significant changes that the department warrants that the training be renewed.

g. A child development home provider who has completed training through a child care resource and referral agency or community college within six months prior to initial registration shall be permitted to count the training toward the provider's total training required during the initial registration.

110.10(2) *Approved trainings.*

a. Professional development contact hours can be coaching, education, or training provided by a department-approved entity.

b. Coaching contact hours may only be used to meet up to half of an individual's annual professional development requirement.

c. The department may randomly monitor any state-approved professional development for quality control purposes.

d. Professional development conducted with staff during the hours of operation of the facility, during staff lunch hours, or while children are resting cannot diminish supervision provided to children. The provider cannot be actively engaged in care and supervision while simultaneously participating in training.

e. A professional development organization not approved by the department may submit for review to the department a request for child care training approval. All approvals unless otherwise specified shall be valid for five years. The department will issue its decision within 30 business days of receipt of a complete request.

f. Department-approved entities must provide participants a professional development certificate for approved professional development contact hours.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.11(237A) Child development home registration; child care assistance provider agreement and payment application for nonregistered providers.

110.11(1) Child development home registration.

a. The department will issue a Certificate of Registration form when an applicant meets all requirements for registration.

b. Registration will be denied or revoked if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under the health and safety rules. Registration may also be denied or revoked if the department determines that the provider has failed to comply with standards imposed by law and these rules.

110.11(2) Child care assistance provider agreement and payment application for nonregistered providers decision.

a. The department will approve a payment agreement application when an applicant meets the requirements.

b. The child care assistance provider agreement will be denied or revoked if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under the health and safety rules. The child care assistance provider agreement may also be denied or revoked if the department determines that the provider has failed to comply with standards imposed by law and these rules.

110.11(3) Record checks.

a. State and national record checks. The department will conduct Iowa criminal history record and child abuse record checks for each registrant, substitute or staff member, anyone living in the home who is 14 years of age or older, and anyone having access to a child when the child is alone. The department will conduct national criminal history record checks, based on fingerprints, for each registrant, substitute or staff member, anyone living in the home who is 18 years of age or older, and anyone 18 years of age or older having access to a child when the child is alone. In accordance with Iowa Code section 726.23, minors under the age of 18 will not be subject to the fingerprint requirement.

(1) The purpose of these record checks is to determine whether a person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal history record and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or other states.

b. Authorization. The person subject to record checks shall complete the Record Check Authorization form, Waiver Agreement form, federal fingerprint card, and any other forms required by the department of public safety to authorize the release of records.

c. Iowa records checks. Checks and evaluations of Iowa child abuse and criminal history records will be completed before the person's involvement with child care. Iowa records checks will be repeated at a minimum of every two years and when the department or the registrant becomes aware of any possible transgressions committed by that person. The department is responsible for the cost of conducting the Iowa records checks.

d. National criminal history record checks. Fingerprint-based checks of national criminal history records will also be completed before a person's involvement with child care. This requirement will be for an initial application for registration or a renewal application for registration. The national criminal history record check will be repeated for each person subject to the check every four years and when the department or registrant becomes aware of any new transgressions committed by that person in another state. The department is responsible for the cost of conducting the national criminal history record check.

(1) The registrant/provider is responsible for any costs associated with the taking of fingerprints of all persons subject to record checks and for submitting the fingerprints to the department so that the national criminal history record check can be completed. Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking fingerprints and are approved by the department.

(2) The department will provide fingerprints to the department of public safety no later than ten business days after receipt of the fingerprint cards. The department will submit the fingerprints on forms or in a manner prescribed by the department of public safety.

(3) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child development home or child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

e. Mandatory and mandatory time-limited prohibition. A person with any convictions or founded abuse reports as defined in Iowa Code section 237A.5(2)*"i"* is prohibited from involvement with child care.

f. Evaluation required. For all other transgressions, and as requested, the department will evaluate the transgression and make a decision about the person's involvement with child care.

(1) The person with the transgression shall complete and return the Record Check Evaluation form within ten calendar days of the date on the form. The department will use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and return this form within ten calendar days of the date on the form shall result in denial or revocation of the registration certificate.

(2) The department may use information from the department's case records in performing the evaluation.

(3) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and the person has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person's employment by the department in the previous evaluation shall remain applicable in the person's subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

g. Evaluation decision. The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements or corrective action plan.

(1) Within 30 calendar days of receipt of a completed record check evaluation, the department will make a decision on the person's involvement with child care.

(2) Within 30 calendar days of receipt of a completed record check evaluation, the department will mail to the person subject to an evaluation a record check decision that explains the decision reached regarding the evaluation of the transgression and a notice of decision.

(3) The department will issue a notice of decision prohibiting involvement with child care when the person subject to an evaluation fails to complete the record check evaluation within the ten-calendar-day time frame.

(4) If the department determines, through the record check evaluation process, that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(5) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training or an individually designed corrective action plan, or both. For an employee of a registrant, these conditional requirements shall be developed with the registrant. All conditions placed on a person's involvement with child care shall be communicated, in writing, to both the person subject to the evaluation and the registrant.

(6) The department will reevaluate any transgressions where a state or federal law change requires different considerations of the transgression than had been previously applied.

h. Notice to parents of abuse in care. If there has been founded child abuse committed by an owner, director, or staff member of the child care facility or child care home, the department's administrator shall notify the parents, guardians, and legal custodians of each child for whom the facility or child care home provides care.

(1) The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parent, guardian, or custodian of each child for whom the facility provides child care.

(2) This information shall be provided to the department within ten calendar days from the date of the initial request.

(3) Failure or refusal to provide the requested information may result in cancellation of the provider agreement.

110.11(4) If the department has denied or revoked a registration or child care assistance provider agreement because the provider has continually or repeatedly failed to operate in compliance with Iowa Code chapter 237A and this chapter, the person cannot own or operate a registered facility for a period of 12 months from the date of denial or revocation. The department will not act on an application for registration submitted by the applicant or provider during the 12-month period. The applicant shall be prohibited from involvement with child care unless the department specifically permits the involvement.

110.11(5) If a certificate of registration or child care assistance provider agreement is revoked, the department will notify the parent, guardian, or legal custodian of each child for whom the facility provides care. The provider shall cooperate with the department in providing the name and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

110.11(6) Required notifications to the department. The provider shall, within ten days, notify the department of any of the following:

a. Changes in assistants or substitutes;

b. Changes in household membership;

c. Address changes; and

d. Criminal convictions.

110.11(7) No assistant, substitute, or co-provider shall be utilized in the care of children and no person shall be permitted to reside in the household until approved by the department.

110.11(8) If the provider does not notify the department of changes within ten days, the provider may be subject to revocation of registration or to recoupment of child care assistance provided, or both.

110.11(9) Notice of child development home revocation. A notice received by an owner or operator of a child development home initiating action to deny or revoke the home's registration shall be conspicuously posted where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny or revoke an owner's or operator's certificate of registration.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.12(237A) Complaints. The department will conduct a visit when a complaint is received.

110.12(1) After each complaint visit, the department will document whether the child development home or nonregistered child care home was in compliance with health and safety requirements.

110.12(2) The written documentation of the department's conclusion as to whether the child development home or nonregistered child care home was in compliance with requirements will be available to the public. However, the identity of all complainants will be confidential unless expressly waived by the complainant.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.13(237A) Additional requirements for child development home category A. In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category A shall meet the following standards.

110.13(1) *Limits on number of children in care.*

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, no more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three can be 12 months of age or younger.

c. In addition to the six children not in school, no more than two children who attend school can be present.

d. No more than eight children shall be present at any one time when an emergency school closing is in effect.

110.13(2) *Provider qualifications.*

a. The provider shall be at least 18 years old.

b. The provider shall have three written references that attest to character and ability to provide child care.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.14(237A) Additional requirements for child development home category B. In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category B shall meet the following standards.

110.14(1) *Limits on number of children in care.*

a. No more than eight children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these eight children, no more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three can be 12 months of age or younger.

c. In addition to the eight children not in school, no more than four children who attend school can be present.

d. No more than 12 children shall be present at any one time when an emergency school closing is in effect.

e. If more than eight children are present at any one time for a period of more than two hours, the provider shall be assisted by a department-approved assistant unless extra children are present as a result of an emergency school closing.

110.14(2) *Provider qualifications.*

a. The provider shall be at least 20 years old.

b. The provider shall have a high school diploma, a GED, or documentation of current or previous enrollment in credit-based coursework from a postsecondary educational institution that is an accredited college or university.

c. The provider shall have either:

(1) Two years of experience as a registered or nonregistered child care provider or a child care center experience, or

(2) A child development associate credential or any two-year or four-year degree in a child care-related field and one year of experience as a registered or nonregistered child care home provider or child care center experience.

110.14(3) *Facility requirements.*

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor cannot be permitted for child care.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.15(237A) Additional requirements for child development home category C without a co-provider. In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category C without a co-provider shall meet the following standards.

110.15(1) *Limits on number of children in care.*

a. No more than eight children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these eight children, no more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three can be 12 months of age or younger.

c. In addition to the eight children not in school, no more than four children who attend school can be present.

d. No more than 12 children shall be present at any one time when an emergency school closing is in effect.

e. If more than eight children are present at any one time for a period of more than two hours, the provider shall be assisted by a department-approved assistant unless extra children are present as a result of an emergency school closing.

110.15(2) *Provider qualifications.*

a. The provider shall be at least 21 years old.

b. The provider shall have a high school diploma, a GED, or documentation of current or previous enrollment in credit-based coursework from a postsecondary educational institution that is an accredited college or university.

c. The provider shall have either:

(1) Four years of experience as a registered, nonregistered child care provider, child care center experience, or

(2) A child development associate credential or any two-year or four-year degree in a child care-related field and four years of experience as a registered or nonregistered child care home provider.

110.15(3) *Facility requirements.*

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor cannot be permitted for child care.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.16(237A) Additional requirements for child development home category C with co-provider. In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category C with a co-provider shall meet the following standards.

110.16(1) *Limits on number of children in care.*

a. No more than 14 children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these 14 children, no more than 6 children who are 24 months of age or younger shall be present at any one time. Whenever four children who are under the age of 12 months are in care, both providers shall be present.

c. In addition to the 14 children not in school, no more than 2 children who attend school can be present.

d. No more than 16 children shall be present at any one time when an emergency school closing is in effect.

e. If more than eight children are present, both providers shall be present.

110.16(2) *Provider qualifications.*

a. The provider shall be at least 21 years old.

b. The provider shall have a high school diploma, a GED, or documentation of current or previous enrollment in credit-based coursework from a postsecondary educational institution that is an accredited college or university.

c. The provider shall have either:

(1) Four years of experience as a registered or nonregistered child care provider or a child care center experience, or

(2) A child development associate credential or any two-year or four-year degree in a child care-related field and four years of experience as a registered or nonregistered child care home provider.

d. The co-provider shall meet the requirements of subrule 110.14(2).

e. No more than two named providers shall be allowed on a registration certificate.

110.16(3) *Facility requirements.*

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor cannot be permitted for child care.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.17(237A) Relative care exemptions. Relatives who are providing care for relative children as a nonregistered child care home are required to meet minimal health and safety standards as contained in the child care and development block grant under 45 CFR 98.41 as amended to August 1, 2026, and this chapter, with the following exemptions:

110.17(1) Facility requirements as set forth in subrule 110.8(1).

110.17(2) Emergency plans as set forth in subrule 110.8(4).

110.17(3) Children's files as set forth in subrule 110.9(4).

110.17(4) Required training as set forth in subrule 110.10(1).

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.18(237A) Registration actions for nonpayment of child support. The department will revoke or deny the issuance or renewal of a child development home registration upon the receipt of a certificate of noncompliance from child support services according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter apply.

110.18(1) *Service of notice.* The notice required by Iowa Code section 252J.8 will be served upon the applicant or registrant in writing. Alternatively, the applicant or registrant may accept notice personally or through authorized counsel.

110.18(2) *Effective date.* The effective date of the revocation or denial of the registration as specified in the notice required by Iowa Code section 252J.8 will be 60 days following service of the notice upon the applicant or licensee.

110.18(3) *Preparation of notice.* The department is authorized to prepare and serve the notice as required by Iowa Code section 252J.8.

110.18(4) *Responsibilities of registrants and applicants.* Registrants and registrant applicants shall keep the department informed of all court actions, and all child support services actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in the actions, and withdrawals of certificates of noncompliance by the child support services.

110.18(5) *District court.* A registrant or applicant may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

a. The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

b. For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a registration, the department will count the number of days before the action was filed and the number of days after the action was disposed of by the court.

110.18(6) *Procedure for notification.* The department will notify the applicant or registrant in writing within ten days of the effective date of the revocation of a registration or the denial of the issuance or renewal of a registration and will similarly notify the applicant or registrant when the registration is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

110.18(7) *Appeal rights.* Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue but may request a court hearing pursuant to Iowa Code section 252J.9.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

441—110.19(237A) Prohibition from involvement with child care. If the department has prohibited a person or program from involvement with child care, that person or program cannot provide child care as a nonregistered child care home provider.

[**ARC 0691D**, IAB 10/28/26, effective 1/1/27]

These rules are intended to implement Iowa Code section 234.6 and chapter 237A.

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[1] January 1, 2015, effective date of ARC 1636C [110.5(1)“a”] delayed 70 days by the Administrative Rules Review Committee at its meeting held October 14, 2014.

CHAPTER 111
FAMILY-LIFE HOMES
[Prior to 7/1/83, Social Services[770] Ch 111]
[Prior to 2/11/87, Human Services[498]]

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

441—111.1(249) Definitions.

"Eligible adult" means a person 18 years of age or older who meets the eligibility requirements for services or is a recipient of protective services and who is considering or needs a living arrangement in a family-life home.

"Encouragement to share in the interests and activities of the household" means that the family welcomes and encourages the person to participate with the family in the family's general family conversations and in the family's social, recreational, educational, and religious activities; the family invites and encourages use of the general facilities of the family's home; and the family expects the person to care for the person's assigned living quarters and to participate within reason in the chores of the household.

"Essentially capable of physical self-care" means the person is ambulatory or can move from place to place; can manage the activities of daily living, including personal hygiene and grooming, toileting, dressing and undressing, feeding, and medicating; and can attend to the care of personal property adequately with minimal support or occasional assistance.

"Family" means a person or persons, either related or unrelated to the client, who constitute the members of the household and are related to one another by kinship of blood, marriage, or adoption.

"Family-life home" means a private household offering a protective social living arrangement for one or two eligible adults who are not able or willing to adequately maintain themselves in an independent living arrangement but who are essentially capable of physical self-care. In this living arrangement, the family provides the client room, board, laundry, encouragement to share in the interests and activities of the household, and opportunities for participation in the social, cultural, educational, religious, and other activities of the community.

"Not able or willing to adequately maintain themselves in an independent living arrangement" means that the person requires some assistance, encouragement, or social stimulation for adequate self-care or to maintain physical or mental health or personal safety.

"Private household" means a dwelling unit occupied exclusively by a family and furnished by and belonging to the family by reason of ownership, rental agreement, or by a contract for purchase of life estate.

[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.2(249) Application for certification.

111.2(1) The department will issue a certificate of approval for the operation of a family-life home upon the recommendation of a local office of the department.

111.2(2) Any person has the right to make application for a family-life home certificate.

111.2(3) Persons wishing to care for adults shall make application to the local office of the department.

111.2(4) When an applicant has reached a decision to operate a family-life home, the applicant shall complete an Application for Certification form.

111.2(5) Each applicant shall supply two references who may be contacted by the local office of the department.

[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.3(249) Provisions pertaining to the certificate.

111.3(1) No family-life home shall be certified to provide a living arrangement for more than two eligible adults.

111.3(2) At least one responsible adult member of the family shall be at the family dwelling or be reasonably available to the client during most of the daytime and nighttime hours, based on the service worker's assessment of the individual's need for supervision.

111.3(3) The certificate shall be effective for one year from the date issued subject to continued compliance with rules governing the program.

111.3(4) The certificate shall not be transferred to another person nor be valid for an address other than that shown on the certificate issued.

111.3(5) A current certificate shall be in the possession of the certified family-life home and be available for inspection.

111.3(6) There will be no fee nor charge for the certificate issued.

111.3(7) A certified family-life home shall not be concurrently licensed as a residential care facility, intermediate care facility, child care center or a foster family home. An exception may be made for a home to be concurrently licensed as a foster family home and certified as a family-life home in order to provide continued care for a person who was placed in the home as a foster child.

[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.4(249) Physical standards.

111.4(1) The family-life home shall be safe, clean, well-ventilated, and properly lighted and heated. The family's dwelling shall comply with all local health ordinances.

111.4(2) The family's dwelling shall not be a dwelling unit furnished by or belonging to a client.

111.4(3) Sleeping rooms shall be suitably and comfortably furnished.

111.4(4) Each resident shall have a single bedroom unless there is agreement among the family and the residents that a room may be shared.

111.4(5) The family shall provide nutritional food in sufficient quantity to meet the needs of the client.

[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.5(249) Personal characteristics of family-life home family.

111.5(1) The adult head of the private household shall be a mature, responsible individual who is physically able to maintain a private household and who shall exercise good judgment in caring for adults.

111.5(2) The family shall have an appreciation of and respect for the client's relationship with the client's own relatives, neighbors and friends.

111.5(3) The family shall respect the client's religious background and affiliation.

111.5(4) The family shall have sufficient income and resources to provide adequately for the family's own needs.

[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.6(249) Health of family.

111.6(1) Prior to certification, the family shall furnish the local office of the department with a medical report on each member of the household. The report shall be on a Provider Health Assessment form.

111.6(2) The medical report shall provide significant findings of a physician, such as the presence or absence of any communicable disease.

111.6(3) Medical reexaminations may be required at the discretion of a physician or the local office of the department.

[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.7(249) Planned activities and personal effects.

111.7(1) The daily routine shall be to promote and provide an opportunity for normal activity with time for rest and recreation compatible with the needs of the client.

111.7(2) Every client shall be encouraged to develop social relationships through participation in neighborhood and other community and group activities.

111.7(3) The family shall not require a client to do general housecleaning, cooking, or child care for the family. A client may voluntarily share in these responsibilities.

111.7(4) Space shall be provided where a client may keep personal belongings.
[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.8(249) Client eligibility.

111.8(1) The client shall be 18 years of age or older as proven by birth or school records, personal records, or by records of the department or another agency.

111.8(2) The client shall be willing to live in a certified family-life home by the client's own declaration or the declaration of a person legally responsible for such client.

111.8(3) The client shall be willing to accept the terms and requirements of the family-life home program.

111.8(4) The client shall be capable of personal physical self-care.
[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.9(249) Medical examinations, records, and care of a client.

111.9(1) A physician shall certify that the client is free from any communicable disease and does not require a higher level of care than that provided by a family-life home. The certification shall be given prior to placement and following an annual medical review thereafter. The certification shall be given on a Physician's Report Health Care Plan form.

111.9(2) The family shall have available, at all times, the name, address and telephone number of the client's physician.

111.9(3) The family shall keep the department informed of any health problems. The family shall immediately notify the department in case of an accident, illness, or emergency that may affect the placement.
[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.10(249) Placement agreement. The head of the family-life home and the resident shall enter into a placement agreement by signing a Family Life Home Placement Agreement form.
[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.11(249) Legal liabilities. The department will advise the family to seek counsel regarding the family's needs for insurance to cover personal injury, property damage, and other legal contingencies.
[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.12(249) Emergency care and release of client.

111.12(1) In case of an emergency, vacation, or overnight trip, requiring the family's temporary absence from the home, the local office of the department shall be notified and arrangements shall be made with a designated, responsible person for the care of a client during the period of absence.

111.12(2) The department shall be notified when the client leaves or the client or family expresses a desire for the client to leave the family-life home.
[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

441—111.13(249) Information about client to be confidential. Information concerning a client, the client's family, and the client's background shall be regarded and handled as confidential by all persons involved in the client's care.
[**ARC 0348D**, IAB 6/10/26, effective 8/1/26]

These rules are intended to implement Iowa Code sections 234.6(1)*"e"* and 249.3(2)*"a"*(1).

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CHAPTER 112
LICENSING AND REGULATION OF CHILD FOSTER CARE FACILITIES

[Prior to 7/1/83, Social Services[770] Ch 112]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

441—112.1(237) Applicability. This chapter relates to licensing procedures for all child foster care facilities authorized by Iowa Code chapter 237. Rules relating to specific types of facilities are located in 441—Chapter 113, "Licensing and Regulation of Foster Family Homes," 441—Chapter 114, "Licensing and Regulation of All Group Living Foster Care Facilities for Children," 441—Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," and 441—Chapter 116, "Licensing and Regulation of Residential Facilities for Children with an Intellectual Disability or Brain Injury."

This rule is intended to implement Iowa Code chapter 237.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—112.2(237) Definitions.

"Administrator," when used for matters related to licensing, means the administrator of the division of adult, children and family services.

"Administrator's designee:"

1. For group facilities, the administrator's designee is the chief of the bureau of child welfare and community services.
2. For foster family homes, the designee is the department of human services' service area manager.

"Applicant:"

1. For a foster family home license, the applicant is the person or persons applying.
2. For a proprietary facility, the applicant is the owner or designee of the facility.
3. For facilities having a board of directors, the applicant may be the president of the board or the board's designee.

"Community residential facility" means a facility which provides care for children who are considered unable to live in a family situation due to social, emotional or physical disabilities but are capable of interacting in a community environment with a minimum amount of supervision. The facility provides 24-hour care including board and room. Community resources are used for education, recreation, medical, social and rehabilitation services. The facility is responsible for planning the daily activities of the children, discipline, guidance, peer relationships, and recreational programs.

"Comprehensive residential facility" means a facility which provides care and treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual service plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, and mechanical restraints when these controls meet licensing requirements.

"Foster family home" means a home in which an individual person or persons or a married couple who wishes to provide or is providing, for a period exceeding 24 consecutive hours, board, room, and care for a child in a single family living unit.

"Group facility" means a community residential facility, a comprehensive residential facility, or a residential facility for children with an intellectual disability.

"Residential facility for children with an intellectual disability or brain injury" means any residential facility which serves children with an intellectual disability as defined in Iowa Code chapter 222 or children with brain injury as defined in Iowa Code chapter 225C.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—112.3(237) Application for license.

112.3(1) *Right to apply.* Any adult individual or agency has the right to apply for a license.

a. Foster family care. A person wishing to apply to be a foster parent shall contact the department's recruitment and retention contractor in the applicable service area to request an application packet. This procedure also applies to:

(1) Persons wishing to care for children placed through any public or private agency.

(2) A relative who is caring for a child directly placed by the child's parents, guardians, or another relative and who wishes to be licensed as a foster parent.

b. Group care. A person wishing to apply for a group care license may contact the department:

(1) Using the "Contact Us" link found on the department's Internet site at dhs.iowa.gov; or

(2) By mail to the Iowa Department of Human Services, Division of Adult, Children and Family Services, Attn: Group Care Licensing, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

112.3(2) *Decision to operate a facility.*

a. When an applicant has reached a decision to operate a foster family home, the applicant shall complete Form 470-0689, Foster Family Home License Application.

b. When an applicant has reached a decision to operate a group facility, the applicant shall complete Form 470-0723, Application for License or Certificate of Approval.

112.3(3) *Withdrawal of an application.* The applicant shall report the withdrawal of an application promptly to the department.

112.3(4) *Evaluation of the application.* Each application will be evaluated by the department to ensure that all standards are met.

a. Before it results in adverse action, a founded abuse report on a director, a sole proprietor involved in the facility's operation, or any facility staff or foster parent applicant shall be evaluated by the department to determine if the abuse merits prohibition of employment or licensure.

b. The department shall evaluate all founded child abuse on a case-by-case basis. Considerations shall include, but not be limited to:

(1) The facility's response (e.g., immediate termination of involved staff).

(2) Whether the abuse was an isolated incident or is symptomatic of a broader, systemic problem.

112.3(5) *Reports and information.* Requested reports and information relevant to the licensing determination shall be furnished to the department by the applicant.

112.3(6) *Applications for renewal.*

a. The department or its agent shall send the licensee an application for renewal 90 days before the license expires. Applications for license renewal shall be made on the form specified in subrule 112.3(2).

b. Applications for renewal shall be made at least 30 but no more than 90 days before the license expires. Applications for renewal of a group care license shall be submitted to the address in subparagraph 112.3(1)*"b"*(2). Applications for renewal of a foster family home license shall be submitted to the recruitment and retention contractor.

c. The department shall approve or deny an application for license renewal through the same process as that used for the original application.

112.3(7) *Notification.*

a. Foster family homes.

(1) The department shall notify an applicant of the approval or denial of an initial license within 140 days of the date that the applicant begins the preservice training required in 441—subrule 113.8(1). When preservice training is waived, the department shall notify the applicant of approval or denial within 120 days of the date that the training waiver is granted.

(2) The department shall notify a licensee of the approval or denial of license renewal within 90 days of reapplication.

b. Group facilities. The department shall notify a group facility of approval or denial of a license within 90 days of application or reapplication.

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—112.4(237) License.

112.4(1) A new license shall be obtained when the licensee moves or the facility is remodeled.

112.4(2) A new license shall be requested when the facility wishes to be licensed for a different number of children.

112.4(3) When corrective action is completed on or before the date specified on a provisional or renewal license, a full license shall be issued for the remainder of the licensure term.

112.4(4) When the corrective action is not completed by the date specified on a provisional or renewal license, a full license shall be denied.

112.4(5) The department shall issue Form 470-0727, Certificate of License, without cost to any foster family that meets the standards. The department shall issue Form 470-3623, Certificate of License, without cost to any group facility that meets the standards. The department may offer consultation to assist applicants in meeting the standards.

112.4(6) A foster family home license shall be approved for a term of one year for the first and second years of licensure. Thereafter, the license shall be approved for a term of two years unless it is determined by the administrator that a one-year license shall be issued. A group facility license shall be approved for a term of one to three years according to the following criteria:

a. A one-year license may be approved for all new facilities that meet licensure standards.

b. A one- to two-year license may be approved when it is determined:

(1) Some health or safety concerns have been identified; or

(2) Some complaints against a facility have been substantiated; or

(3) Deficiencies have been identified.

c. A three-year license may be approved when:

(1) No health or safety deficiencies have been identified;

(2) There have either been no substantiated complaints against the facility or, if substantiated, complaints have been determined not to be serious or severe; and

(3) A facility has no founded incidents of child abuse by facility staff.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 0356C**, IAB 10/3/12, effective 12/1/12; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—112.5(237) Denial.

112.5(1) The department shall deny the license application when:

a. The minimum standards set forth in these rules are not met and a provisional license is inappropriate or disapproved by the administrator or administrator's designee.

b. For just cause.

c. The applicant, as a sole proprietor or a foster family home parent, or any person residing in the foster family home other than a foster child, or any facility staff, has been convicted of a crime unless an evaluation of the crime has been made by the department which concludes that the crime does not merit prohibition of employment or licensure.

d. The applicant, as a sole proprietor or foster family home parent, or any person residing in the foster family home other than a foster child, or any facility staff, has a record of founded child abuse unless an evaluation of the founded abuse has been made by the department which concludes that the abuse does not merit prohibition of employment or licensure.

e. The application is fraudulent, which means that the applicant has knowingly made fraudulent statements or has knowingly concealed information.

112.5(2) Reapplications shall be denied:

a. For the same reasons as original applications.

b. For the same reasons as listed in the grounds for revocation.

c. When the foster family applicant's license has been denied or revoked within the 12 months before the date of reapplication. Denial for this reason does not require a licensing study.

d. If the foster family refuses to engage as a resource to a foster child's birth parents when engagement can be done in a way that does not put the foster family or the foster child at risk of harm.

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—112.6(237) Revocation.

112.6(1) *Mandatory.* The department shall revoke the license for the following reasons unless subrule 112.6(3) applies:

a. When the facility is misusing funds furnished by the department.

b. When the facility is operating without due regard to the health, sanitation, hygiene, comfort, or well-being of the children in the facility.

c. When the director or sole proprietor involved in the operation of the facility, or foster parent, or any person residing in the foster home other than a foster child, or any facility staff has been convicted of a crime unless an evaluation of the crime has been made by the department which concludes that the crime does not merit prohibition of employment or licensure.

d. When there is a founded abuse report on a foster family home parent, any person residing in a foster family home other than a foster child, a director or sole proprietor who is involved in the facility's operation, or any facility staff, unless an evaluation of the founded abuse has been made by the department which concludes that the abuse does not merit prohibition of employment or licensure.

e. Rescinded, effective November 1, 1987.

112.6(2) *Optional.* Licenses may be revoked for any of the following reasons unless subrule 112.6(3) applies:

a. When moving to a new home, the foster family fails to notify the department and the recruitment and retention contractor within seven working days of the move to a new home.

b. Rescinded, effective July 1, 1987.

c. The foster family or facility fails to meet any or all requirements of the placement agreement.

d. Rescinded, effective July 1, 1987.

e. Rescinded, effective July 1, 1987.

f. The child foster care facility fails to continue to comply with all of the licensing requirements in both law and regulation.

g. The foster family or the staff of a licensed group facility refuses to cooperate with an unannounced visit.

112.6(3) *Exceptions.* The license for a foster family home shall not be revoked when there are 30 or fewer days until the date the license expires.

The foster family home shall be advised in writing that a reapplication may be denied and the reasons for the possible denial. The foster family home license may be suspended immediately pursuant to rule 441—112.9(237).

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 2069C**, IAB 8/5/15, effective 10/1/15]

441—112.7(237) Provisional license.

112.7(1) *Time frame for provisional licenses.* The administrator may issue a provisional license for not more than one year when a licensee's facility does not meet the requirements of this chapter and the licensee submits a written corrective action plan that is approved by the administrator to bring the facility into compliance with the applicable requirements.

112.7(2) *Written report.* The administrator or the administrator's designee will provide a report identifying the reasons for the provisional license and the standards that have not been met.

112.7(3) *Corrective action plan.* The facility shall furnish the licensing agency with a plan of action to correct deficiencies listed that resulted in the provisional license. The plan shall give specific dates upon which the corrective action will be completed.

This rule is intended to implement Iowa Code section 237.5.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—112.8(237) Adverse actions. Notice of adverse actions and the right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7. Any issues of placement or payment are independent of the licensing decision and right of appeal.

This rule is intended to implement Iowa Code section 237.5.

441—112.9(237) Suspension.

112.9(1) *Types of suspension.* There are two types of suspension of a license.

a. Emergency suspensions are to prevent persons from providing foster care by suspending their license until it is revoked or denied.

b. Time-limited suspensions are to prevent persons from providing foster care by suspending their license until a deficiency in the home or facility is corrected.

112.9(2) *Requirements for emergency suspension.* The emergency suspension of a license by the administrator or administrator's designee shall occur only when all of the following conditions exist:

a. The licensee fails to meet licensing requirements.

b. There are sufficient grounds for revocation on denial of the license.

c. The health, safety, and welfare of any child placed in the home or facility requires immediate action.

d. The existence of the condition requiring suspension is documented in the licensee's record.

112.9(3) *Requirements for time-limited suspensions.* The time-limited suspension of a license by the administrator or administrator's designee shall occur only when all of the following conditions exist:

a. The licensee fails to meet licensing requirements.

b. The health, safety, and welfare of any child placed in the home or facility requires immediate action.

c. The existence of the condition requiring suspension is documented in the licensee's record.

d. The condition requiring the suspension can be corrected by the licensee to meet licensing requirements.

e. If the condition were corrected, a full license would be issued.

f. The licensee signs a written statement acknowledging the existence of the condition, citing the law or rule violated, and making a commitment to correct the condition within a specific time period, not to exceed the period of the license.

112.9(4) *Effective period of suspensions.* A suspension shall be effective on the date the notice is received by the licensee and shall remain in effect until one of the following occurs:

a. The department withdraws the suspension due to a change in conditions in the home or facility.

b. The court orders the license reinstated.

c. The action is reversed by a final decision in accordance with 441—Chapter 7.

d. For emergency suspensions, a revocation or denial becomes effective and the license is rescinded.

e. The licensing period expires.

f. For time-limited suspensions, the period of suspension ends.

112.9(5) *Method and content of notice.* The notice of suspension shall be sent by restricted certified mail or personal service and shall include the following:

a. The condition requiring the suspension.

b. The specific law or rule violated.

c. The type of suspension.

d. For an emergency suspension, the adverse action being sought by the department.

e. For a time-limited suspension, the duration of the suspension.

112.9(6) *Right to appeal suspension.* The licensee has the right to appeal the suspension of the license, but initiation of an appeal does not alter the suspension.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—112.10(232) Mandatory reporting of child abuse and training.

112.10(1) *Mandatory reporters.* All defined in Iowa Code section 232.69 who, in the scope of professional practice or in their employment responsibilities, examine, attend, counsel, or treat a child and reasonably believe a child has suffered abuse shall make a report in accordance with Iowa Code section 232.69 whenever the provider reasonably believes a child for whom the provider is providing foster care has suffered abuse.

112.10(2) *Required training.* Mandatory reporters shall receive training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69.

112.10(3) *Training documentation.* Each licensee shall develop and maintain a written record for each mandatory reporter in order to document the content and amount of training.

This rule is intended to implement Iowa Code section 232.69.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—112.11(237) Required training on the reasonable and prudent parent standard. Each group facility shall have an on-site official authorized to apply the reasonable and prudent parent standard as defined in rule 441—202.1(234). Within one year of being identified as an authorized on-site official, each authorized official shall complete the same department-approved training on the reasonable and prudent parent standard in the same manner as required for prospective foster parents and referenced in 441—subrule 117.1(4).

[**ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—112.12(237) Record checks. Record checks as defined in 441—Chapter 114 are required for any entity being considered for licensure or employment by a licensee on a facility campus where children reside to determine whether any applicant has any founded child abuse reports or criminal convictions or has been placed on a sex offender registry.

This rule is intended to implement Iowa Code section 237.8.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

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CHAPTER 113
LICENSING AND REGULATION OF FOSTER FAMILY HOMES

[Prior to 7/1/83, Social Services [770] Ch 113]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

441—113.1(237) Applicability. This chapter specifically relates to the licensing and regulation of foster family homes. Refer to 441—Chapter 112 for general licensing rules and regulations which apply to all foster care facilities, including foster family homes.

This rule is intended to implement Iowa Code chapter 237.

441—113.2(237) Definitions.

"Age- or developmentally appropriate activities" means activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

"Child or children" means the child or children who are in foster care for the purpose of this chapter only.

"Corporal punishment" means the intentional physical punishment of the child(ren).

"Department" means the Iowa department of human services and includes the local offices of the department.

"Fictive kin" means an adult person who is not a relative of a child but who has an emotionally significant positive relationship with a child or the child's family.

"Foster family home" means a home in which an individual person or persons or a married couple who wishes to provide or is providing, for a period exceeding 24 consecutive hours, board, room, and care for the child(ren) in a single family living unit.

"Health care provider" means a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner who completes a health report.

"Kinship care" means the care of a child by a relative or fictive kin providing full-time nurturing and protection.

"Kinship caregiver" means a relative or fictive kin providing care for a child.

"Public water supply system (PWS)" means a system for the provision to the public of water for human consumption through pipes or other constructed conveyances, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

"Reasonable and prudent parent standard" means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of the child(ren) while at the same time encourage the emotional and developmental growth of the child(ren), that a caregiver shall use when determining whether to allow the child(ren) in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, and social activities. For the purposes of this definition, "caregiver" means a foster parent with whom the child(ren) in foster care have been placed or a designated official for a child care institution (including group homes, residential treatment, shelters, or other congregate care settings) in which the child(ren) in foster care have been placed.

"Reasonable force" means that force, and no more, which a reasonable person in like circumstances would judge to be necessary to prevent an injury or loss.

"Recruitment and retention contractor" means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents, or any of its subcontractors.

"Relative" means an individual related to the child within the fourth degree of consanguinity or affinity, by marriage, or through adoption. "Relative" includes the parent of a sibling of the child if the sibling's parent's parental rights were not previously terminated in relation to the child.

"Service area manager" means the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Social work administrator" means the department employee responsible for supervising the social work staff within a department service area and for implementing service policies and procedures of the department.

"Variance" means meeting a licensing standard through alternative means.

"Waiver" means waiving the licensing standard entirely. A waiver may only be granted for non-safety licensing standards for a kinship caregiver.

This rule is intended to implement Iowa Code chapter 237.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.3(237) Licensing procedure.

113.3(1) *Application.* Applications for an initial license to operate a foster family home shall be submitted and processed as directed in rule 441—112.3(237). In addition to the application form, the applicant shall submit the following forms during the licensing process:

a. Form 595-1396 for each person living in the home who is 14 years of age or older, as required by rule 441—113.13(237).

b. Form 470-0720 to satisfy the requirements of rule 441—113.11(237).

c. Form 470-0693, if applicable.

d. Form 470-5097. The applicant or the recruitment and retention provider shall complete a drawing of the floor plan of the family's home.

e. If licensed to drive, a copy of the driver's license and motor vehicle insurance.

113.3(2) *Orientation.* Applicants shall attend an orientation provided by the recruitment and retention contractor as described in rule 441—117.2(237).

113.3(3) *Record checks.* Before beginning preservice training, applicants shall pass at least the local record check procedures as specified in rule 441—113.13(237).

113.3(4) *Home study.* The worker for the recruitment and retention contractor shall complete a family home study.

a. Process. Information for the home study is gathered primarily through the required preservice training as described in rule 441—117.1(237). Tribal agencies may also be involved in conducting home studies for American Indian and Alaska Native children. 42 U.S.C.A. Section 671(a)(26)(B) provides that any receiving state must treat any tribal home study report as meeting the requirements imposed by the state for the completion of a home study.

(1) The worker shall hold at least three face-to-face interviews with the applicant with one of the interviews taking place in the applicant's home.

(2) The worker shall hold at least one face-to-face interview with each member of the household in the applicant's home to observe family functioning and to assess the family's capacity to meet the needs of the child(ren) in foster care. The worker will determine whether to interview or just observe each household member based on the household member's age and development.

(3) A physical inspection of the home is required. The worker shall use Form 470-0695 to complete the physical inspection of the home to verify compliance with the licensing and regulation standards in this chapter.

(4) Reference checks shall be conducted as described at rule 441—113.14(237).

b. Family assessment topics. The assessment of the prospective foster family shall evaluate the family's ability to parent the special needs child(ren). The assessment shall include the following:

(1) The applicant's motivation for foster care and whether the family has biological, adopted, or foster child(ren).

(2) The attitude of the family and the extended family toward accepting the child(ren).

(3) The applicant's emotional stability; marital relationship and history, including verification of marriages and divorces; family relationships; and compatibility.

(4) The applicant's ability to cope with problems, stress, frustrations, crisis, separation, and loss.

(5) Medical, mental, and emotional conditions that may affect the applicant's ability to parent the child(ren); treatment history; current status of treatment; and the evaluation of the treatment. Applicants and all household members must disclose any past or current mental health or substance abuse issues, or both. The department may require further documentation or evaluation, or both, to determine the suitability of the home.

(6) Any child(ren) who are household members must be up to date on immunizations jointly recommended by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the American Academy of Family Physicians, unless the immunization is contrary to the child(ren)'s health as documented by a licensed health care professional.

(7) An evaluation of the applicant's willingness to accept the child(ren) who have medical problems (such as a communicable disease), an intellectual disability, or emotional or behavioral problems. The applicant shall complete the department form to indicate choices about caring for any child(ren) who have or are at risk for a communicable disease and other medical problems.

(8) The applicant's ability to provide for the child(ren)'s physical, medical, and emotional needs; to respect the child(ren)'s ethnic and religious identity; and to support the child(ren)'s overall well-being.

(9) The safety of the child(ren) in relation to any animals that live on the applicant's property.

(10) The adjustment of any child(ren) in the home, including their attitudes toward foster care and adoption, relationships with others, and school performance.

(11) An assessment of the applicant's disciplinary techniques and practices.

(12) The applicant's financial information and ability to provide for the child(ren).

(13) The applicant's attitude toward the birth parents and siblings of the child(ren) placed in foster care.

(14) The applicant's commitment to and capacity to maintain significant relationships of the child(ren) in foster care and work with the child(ren)'s parents when the permanency goal is reunification.

(15) Any history of substance use or substance abuse by family members or members of the household, including treatment history and current status of treatment.

(16) Any history of abuse by family members or members of the household, including treatment history, current status of treatment, and how this issue would affect the applicant's ability to be a foster parent.

(17) Any criminal convictions of family members or adults in the household and the evaluation of the criminal record.

c. Written report. The recruitment and retention contractor shall prepare a written report of the family assessment using Form 470-5436. Form 470-5436 shall include a recommendation for the number, age, sex, characteristics, and special needs of the child(ren) the family can best parent and any other pertinent information in making the licensing recommendation. The home study shall be maintained in the foster family record.

113.3(5) *Decision.* The department worker shall use the home study to approve or deny a prospective family as an appropriate placement for the child(ren). The department worker shall notify the family of the licensing decision using Form 470-0709.

a. Upon approval, the department shall issue the applicant a foster family home license as described at rule 441—112.4(237). The license shall indicate the licensed capacity for the number of child(ren) approved for placement in the foster family home under subrule 113.4(1).

b. If the department worker does not approve the home study, the notice shall state the reasons for that decision, as listed in rule 441—112.5(237). A license denial may be appealed as described at rule 441—112.8(237).

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5064C**, IAB 7/1/20, effective 9/1/20; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.4(237) Provisions pertaining to the license. On a case-by-case basis, the service area manager or area social work administrator may waive any non-safety licensing standard for a kinship caregiver or grant a variance for any standard for a non-kinship caregiver in this chapter unless:

1. The requirement is set in state or federal law; or

2. The waiver or variance could have a negative impact on the safety and well-being of the child(ren) placed in the foster family home.

113.4(1) *Number of children.* A foster family home may care for up to five children unless a variance is approved as described in this rule. The license capacity shall be based on the number of the foster family's biological and adoptive children and any relative placements. The license shall be issued for at least one child. Any child(ren) who have reached the age of 18 and remain eligible for foster family care shall be included in the license capacity. Any variance to this rule must:

a. Be approved by the service area manager or designee.

b. Be documented in the licensing record with reasons given for granting the variance.

c. Meet one of the following criteria:

(1) The foster parents have three or more children in the home and have shown the ability to parent a large number of children. A licensing variance may be approved at initial or renewal licensure to allow the placement of up to three children as set forth in the chart below:

No. of Children in the Home (birth/relative/adoptive placements)	Maximum License Capacity:	
	Without variance	With variance
0 children	5	Not applicable
1 child	4	Not applicable
2 children	3	Not applicable
3 children	2	3
4 children	1	3
5 or more children	Not applicable	3

(2) A variance beyond the maximum capacity of the foster home license is needed for the placement of a specific child in foster family care. A child-specific variance shall end when that child leaves the placement or any other change brings the family into licensed capacity. Unless a variance is needed for the placement of a sibling(s) of the child(ren) already in the home, or to keep siblings together, the maximum number of children in the home shall not exceed eight. On a case-by-case basis, if it is determined the foster parents have shown the parenting skills and have the social support system to meet the children's needs for parenting more than eight children, the social work administrator shall approve the foster parents to parent more than eight children. A foster family may have both a licensing and a child-specific variance concurrently.

d. All other licensing requirements including, but not limited to, parenting ability and available bedroom space must be met before a foster home can be approved for a variance.

113.4(2) *Employees of the department as foster parents.* Employees of the department may be licensed as foster family home parents unless they are engaged in the administration or provision of foster care services. Employees engaged in the administration or provision of foster care services include:

a. Child care staff, social workers, youth service workers or their supervisors involved in programs for children in state institutions.

b. Foster care service workers, foster care licensing staff, and their supervisors employed in county or central offices of the department.

c. Other staff engaged in foster care placements, such as child protective staff or adoption workers.

d. Department staff responsible for the development of policies and procedures relating to foster care licensing and placement.

113.4(3) *Limits on foster family home licensure.* A licensed foster family home shall not be permitted to be a licensed comprehensive residential facility, community residential facility, or licensed child care center.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.5(237) Physical standards.

113.5(1) *General standards.* The foster home shall be safe, clean, well ventilated, properly lighted, properly heated, and free from vermin and rodents to ensure the well-being of the child(ren) residing in the home.

113.5(2) *Grounds.*

a. There shall be safe outdoor space provided according to the age and developmental needs of the child(ren) for active play. The area available shall be documented in the case record.

b. The child(ren) shall be adequately supervised and protected against hazards including, but not limited to, traffic, bodies of water, railroads, waste material, and contaminated water. The foster parent shall provide environmental protections such as door alarms, baby monitors, fences, and foliage barriers as necessary to promote a safe environment.

c. The applicant's home must meet the following standards concerning swimming pools, hot tubs and spas:

(1) A child's plastic pool shall be drained daily and shall be inaccessible to the child(ren) when it is not in use. Swimming pools must have a barrier on all sides at least four feet high.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the ASTM International (formerly known as the American Society for Testing and Materials) specification intended to reduce the risk of drowning by inhibiting access to the water by children under five years of age. Swimming pools must have their methods of access through the barrier equipped with a safety device, such as a bolt lock.

(3) Swimming pools must be equipped with a lifesaving device, such as a ring buoy.

(4) If the swimming pool cannot be emptied after each use, the pool must have a working pump and filtering system.

(5) Hot tubs and spas must have safety covers that are locked when not in use.

The foster parent or other adult shall provide reasonable supervision according to the ages and swimming abilities of the child(ren) when they are using the pool.

113.5(3) *Bedrooms for child(ren) placed in the home.*

a. Bedrooms shall either have been constructed for the purpose of providing sleeping accommodation or remodeled for sleeping to provide proper heat and ventilation. Bedroom additions to a home shall meet building code requirements. All bedrooms used by the child(ren) placed in the home shall have:

(1) Permanent walls;

(2) A door that closes;

(3) An unobstructed, operable window that opens from the inside that is large enough to allow for an unrestricted exit by the child(ren) placed in the home;

(4) A closet, wardrobe, armoire, or dresser for the child(ren)'s clothes; and

(5) A standard bed, for infants and toddlers who cannot safely use a standard bed, a crib or crib-like furniture which has a waterproof mattress covering and sufficient bedding to enable the child(ren) to rest comfortably and which meets the current standards or recommendations from the U.S. Consumer Product Safety Commission or ASTM International for juvenile products for each child under two years of age if developmentally appropriate. The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Safe infant sleep practices shall conform to the following standards:

1. Infants shall always be placed on their backs for sleep.

2. Infants shall be placed on a firm mattress with a tight fitting sheet that meets U.S. Consumer Product Safety Commission federal standards.

3. Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child(ren) shall be allowed to sleep in any item not designed for sleeping. This is not referring to a child in a car seat in a car.

4. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

5. No co-sleeping shall be allowed.

6. If an alternate sleeping position is needed for an infant, a signed authorization with a statement of a medical reason is required and shall be submitted by a physician, advanced registered nurse practitioner, or physician assistant.

b. The minimum bedroom area per child shall be 40 square feet. However, the service area manager or designee may approve a waiver of this non-safety licensing standard for kinship caregivers or a variance when approval is in the best interest of specific children placed or to be placed in the home. Such approvals shall:

(1) Be in writing;

(2) Contain the names and birth dates of the child(ren) for whom issued; and

(3) Be reviewed at each license renewal.

c. When bedrooms meet only minimum requirements, the home shall provide additional room in other parts of the home for study and play.

d. The ceiling height for bedrooms shall be adequate for the child(ren).

e. Except for baby video monitors for the child(ren) birth to two years of age used in their bedrooms, video or surveillance cameras are not allowed in the child(ren)'s bedrooms or bathrooms.

f. Bedrooms belowground shall:

(1) Be free from excessive dampness, noxious gases, and objectionable odors;

(2) Have access to at least one direct exit to the outside from the level belowground and one inside stairway exit from the level belowground;

(3) Have an egress window with a clear opening area with an opening height of 24 inches and an opening width of 20 inches or an opening height of 20 inches and an opening width of 24 inches;

(4) Have provisions, such as a ladder or steps, to ensure that the child(ren) can safely reach the window if the finished sill height is more than 44 inches above the floor and that the child(ren) can safely reach ground level if there is a window well that has a depth of 44 inches or higher;

(5) Have a finished ceiling such as drywall or a drop ceiling; and

(6) Have a covered floor.

113.5(4) and **113.5(5)** Rescinded IAB 10/3/12, effective 12/1/12.

113.5(6) *Physical care standards for child(ren).*

a. Grouping children in bedrooms shall take into consideration the age and sex of the child(ren), including the individual child's need for privacy.

(1) Any child(ren) over five years of age shall not share a bedroom with child(ren) of the opposite sex.

(2) The child(ren) shall not share a bed with any other child. The social work administrator may approve a waiver of this policy for kinship caregivers or a variance for non-kinship caregivers.

b. Any child(ren) two years of age or older shall be provided bedroom space other than in the foster parents' bedroom. Any child(ren) under the age of two may share a bedroom with the foster parent in an individual crib.

c. There shall be a plan for isolating the healthy child(ren) from a child who is ill or suspected of having a contagious disease.

d. The foster home shall provide food with good nutritional content and in sufficient quantity to meet the individual needs of the child(ren).

e. Personal care items must be provided for youth, and these items must reflect the individual, cultural, racial, and ethnic needs of the youth living in the foster home.

f. Bedding shall be clean, odor-free, and free of urine and feces.

g. Foster parents shall follow universal precautions to reduce exposure to bloodborne pathogens and other infectious materials when providing care to any child(ren) placed in their physical custody.

h. Smoking and vaping shall be prohibited in the foster home or any vehicle when the child(ren) are present.

113.5(7) *Lead-based paint.* If the applicant lives in a home built before 1978, the applicant shall submit Form 470-4819, certifying that the applicant:

a. Has conducted a visual assessment for lead hazards that exist in the form of peeling or chipping paint; and

b. Has applied interim controls using safe work methods if the presence of peeling or chipping paint is found, unless an inspector certified pursuant to department of public health rules at 641—Chapter 70 has determined that the paint is not lead-based. "Interim controls" are measures designed to temporarily reduce human exposure or likely exposure to lead-based paint hazards, such as repairing deteriorated lead-based paint, specialized cleaning, maintenance, painting, and temporary containment.

113.5(8) *Artificial lighting.* Adequate artificial lighting fixtures shall be provided for study in areas where the child(ren) will be studying.

113.5(9) *Bathroom facilities.*

a. Bathroom facilities shall have at least one toilet, sink, and tub or shower in safe operating condition.

b. Bathroom facilities shall have natural or artificial ventilation.

113.5(10) *Heating plant.*

a. The heating plant shall have a capacity to maintain a temperature of approximately 65 degrees Fahrenheit in the bedrooms with the door closed.

b. Fireplaces and water heaters shall be vented to the outside atmosphere. The temperature of any water heaters must be set in accordance with the manufacturer's recommendations. Kerosene heaters and gas-fired space heaters shall not be used to heat any space in the home.

113.5(11) *Ventilation.* Ventilation shall be provided in all rooms where the child(ren) eat, sleep, and play either by windows which can be opened or by mechanical venting systems. Windows and doors used for ventilation shall be screened.

113.5(12) *Phone.* A working phone or access to a working phone shall be in close walking proximity to an applicant's living space.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0357C**, IAB 10/3/12, effective 12/1/12; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5064C**, IAB 7/1/20, effective 9/1/20; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.6(237) Sanitation, water, and waste disposal.

113.6(1) *Food preparation and storage.* Food preparation areas shall be clean, and the home shall have kitchen facilities with a sink, refrigerator, stove, and oven in safe operating condition.

113.6(2) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system.

113.6(3) *Private water supply.*

a. Prior to initial licensure and prior to each license renewal, each privately operated water supply shall be tested and evaluated for obvious deficiencies, such as open or loose well tops or platforms and poor drainage around the wells.

b. As part of the evaluation, water samples must be collected and submitted by the licensing worker or health sanitarian to the university hygienic laboratory or other laboratory certified by the hygienic laboratory and analyzed for coliform bacteria. In order for a foster family home to be licensed for the care of any child(ren) under two years of age, the nitrate (NO^3) content must be analyzed.

c. When the water supply is obtained from more than one well, proof of the quality of the water from each well is required.

d. When the water sample result shows the water is potable, the license can be granted.

e. When the water sample is not approved, no foster family home license shall be issued until the foster parents provide a written statement that the child(ren) will be provided potable water, including where the water will be obtained and how it will be transported and stored.

(1) The statement shall be provided on Form 470-0699.

(2) When the family has made ongoing alternative arrangements for the use of safe, potable water, annual testing of the water may be waived after the private water supply has tested unpotable for three consecutive years.

113.6(4) *Sewage treatment.*

a. Foster homes, wherever possible, shall be connected to public sewer systems.

b. Private disposal systems shall be designed, constructed and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

113.6(5) *Garbage storage and disposal.*

a. A sufficient number of covered garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly tight, watertight, and rodent proof and shall be maintained in a sanitary condition.

113.6(6) *Rodent and insect infestation.* The home shall prevent or eliminate rodent and insect infestation.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5064C**, IAB 7/1/20, effective 9/1/20; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.7(237) Safety.

113.7(1) *Fire protection for bedrooms.* Any floor of a house, including the basement, shall be equipped with the following:

a. At least one UL (Underwriter's Laboratory)-approved smoke detector. On floors that are used for sleeping, the smoke detector shall be in a location where sleeping areas can be alerted. For any deaf or hard-of-hearing child(ren), the foster parent shall install a smoke detector in the child(ren)'s bedroom that will use an alternative means of waking the child(ren).

b. Hallways and stairways free of debris and clutter to allow unrestricted access to an exit.

c. A working carbon monoxide detector in all homes with:

(1) Gas appliances, furnaces, fireplaces, or other gas equipment; and

(2) Attached garages.

113.7(2) *Combustion hazards.*

a. Combustible materials shall be kept away from heat sources, including but not limited to furnaces, stoves, electrical panels, space heaters, and hot water heaters.

b. Explosives and flammable substances shall be stored securely and be inaccessible to the child(ren). Matches and lighters shall be inaccessible to the child(ren).

c. The home shall have at least one operable 2A-10BC-rated or ABC-rated fire extinguisher.

113.7(3) *Safety plan.* The family shall have an emergency safety plan to be used for fire, tornado, blizzard, flood, other natural or manmade disasters, accidents, medical issues, and other life-threatening situations for the child(ren) in out-of-home placements. The safety plans shall state the action that the foster parents and the child(ren) are to take in each situation that may occur and shall be posted in a prominent place in the home.

a. The safety plans for fire and tornadoes shall be reviewed with the child(ren) at the time of placement. Fire and tornado plans shall be practiced with the child(ren) within one week of placement and no less than annually thereafter.

b. In a disaster requiring evacuation of the foster home, the foster parents shall notify the department of the evacuation and the address and telephone number of the foster parents' temporary residence within 24 hours after evacuation.

c. The plans shall include a designated meeting place.

d. Applicants must maintain a comprehensive list of emergency telephone numbers, including poison control, and post those numbers in a prominent place in the home. If there is a landline phone located in the home, the numbers must be posted next to the phone.

113.7(4) *Medications, first aid and poisonous substances.*

a. All prescription medication shall be administered as prescribed and documented in a medication log that is given to the child(ren)'s department caseworker when the child(ren) leave the placement.

b. All over-the-counter medications shall be administered according to label directions or as directed by a physician.

c. Applicants must prevent the child(ren)'s access, as appropriate for the child(ren)'s age and development, to all medications, poisonous materials, cleaning supplies, other hazardous materials and alcoholic beverages.

d. Applicants must maintain first aid supplies as recommended by the American Red Cross.

113.7(5) *Weapons.* All weapons, firearms, and ammunition shall be inaccessible to the child(ren) of any age.

a. The following weapons must be stored in an inoperative condition in a locked area inaccessible to the child(ren):

(1) Firearms;

(2) Air guns;

(3) BB guns;

(4) Hunting slingshots;

(5) Any other projectile weapons.

b. All ammunition, arrows or projectiles for such weapons shall be maintained in a locked place separate from the firearms.

c. The weapons, firearms, and ammunition storage units shall not share the same key or matching security code. If a key is used, the key shall be stored in a place inaccessible to the child(ren).

d. Any motor vehicles used to transport the child(ren) shall not contain a loaded gun, and any ammunition in the vehicle shall be kept in a separate, locked container.

e. Foster parents who have a permit to carry a firearm shall sign Form 470-4657. Foster parents who have firearms but do not have a permit to carry shall complete the safety plan section of Form 470-4657.

f. Foster parents who are also law enforcement officials and can document that their jurisdiction requires them to have ready and immediate access to their weapons may be exempt from these weapon requirements provided they adopt and follow a safety plan approved by the department.

113.7(6) *Transporting child(ren).*

a. Foster parents will ensure that if a privately owned vehicle, owned by the applicants, family or friends, is used to transport the child(ren) in foster care, it must be inspected (if applicable under state law), registered, and insured and meet all applicable state or tribal requirements to be an operable vehicle on the road.

b. The driver will have a valid Iowa driver's license.

c. Safety restraints will be used that are appropriate to the child(ren)'s age, height, and weight.

d. Any motor vehicles used to transport the child(ren) shall be smoke-free when the child(ren) are being transported.

e. Weapons must not be transported in any vehicle in which the child(ren) are riding unless the weapons are made inoperable and inaccessible.

f. Foster parents will have access to reliable public transportation if they do not have access to a reliable, registered, and insured vehicle.

113.7(7) *Supervision.* The foster parents shall provide reasonable and prudent supervision of the child(ren) to ensure the child(ren)'s safety.

a. Foster parents shall adequately supervise the child(ren) while the child(ren) are using any hazardous or dangerous objects or equipment. In order for the child(ren) to participate in age- or developmentally appropriate activities, the foster parent would apply the reasonable and prudent parent standard.

b. Foster parents shall use reasonable and prudent supervision of the child(ren) when the child(ren) are using the Internet or other social media.

113.7(8) *Household pets.* Household pets and any outdoor animals or pets accessible to the child(ren) shall have a current veterinary health certificate verifying that the animal's routine immunizations, e.g., rabies, are current.

a. At the time of the initial home study and any time thereafter, foster parents shall report an animal's history of aggression towards people and inform the department of the animal's aggression towards people within 24 hours of an occurrence.

b. Foster parents who have pets or animals with any history of aggression shall have a written plan that addresses strategies to reduce the risk of aggression by their pets or animals with which the child(ren) will have contact.

c. Foster parents will complete a written plan on how they will introduce a pet to the child(ren).

d. Animal waste will be contained and disposed of on a routine basis.

113.7(9) *Liability.* Foster parents who apply the reasonable and prudent parent standard reasonably and in good faith in regard to the child(ren) placed in their home shall have immunity from civil or criminal liability which might otherwise be incurred or imposed. This subrule shall not remove or limit any existing liability protection afforded under any other law.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0357C**, IAB 10/3/12, effective 12/1/12; **ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5064C**, IAB 7/1/20, effective 9/1/20; **ARC 5808C**, IAB 7/28/21, effective 9/1/21; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.8(237) Foster parent training.

113.8(1) *Preservice training.* All foster parent applicants shall complete the following training before licensure and the placement of the child(ren) in their home:

a. Orientation pursuant to rule 441—117.2(237);

b. Preservice training pursuant to rule 441—117.1(237);

c. Preservice training, which shall include:

(1) An agency-approved medication management training,

(2) A face-to-face cardiopulmonary resuscitation (CPR) and first-aid training,

(3) Mandatory reporter training on child abuse identification,

(4) The reasonable and prudent parent standard training,

(5) Lessons teaching foster parents how to support a child's overall well-being and emotional needs; and

d. Mandatory reporter training on child abuse identification and reporting before initial licensure and every three years thereafter as required by rule 441—112.10(232) and 441—subrule 117.8(3).

113.8(2) *In-service training.* All licensed foster parents shall complete six hours of in-service training annually as required by rule 441—117.7(237).

Each foster parent shall maintain certification in face-to-face CPR and first-aid training.

This rule is intended to implement Iowa Code section 237.5A.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5361C**, IAB 12/30/20, effective 3/1/21; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.9(237) Involvement of kin.

113.9(1) *Support by foster parents.* Foster parents shall support the involvement of biological or adoptive parents and other relatives of the child(ren) unless this involvement is evaluated and documented by the department to be detrimental to the child(ren)'s well-being.

113.9(2) *Nature of involvement.* The extent and nature of the involvement of the biological or adoptive parents and other relatives shall be determined by the caseworker in consultation with the foster parents, biological or adoptive parents, and others involved with the child(ren) and family.

113.9(3) *Cultural connections.* Throughout the provision of care, the foster family shall actively ensure that the child(ren) stay connected to the child(ren)'s kin, culture, and community as required in the child(ren)'s case permanency plan.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.10(237) Information on the child(ren) placed in the home.

113.10(1) *Information about the child(ren).* Foster parents shall maintain a separate folder of information on the child(ren) placed in the home. This folder shall be provided to the department or the child(ren)'s parent or guardian when the child(ren) leave the placement. The folder shall contain:

a. The names and addresses of all doctors, mental health professionals, and dentists who have treated the child(ren); current medications prescribed, including over-the-counter medications; medication log; and

the type of medical, dental, vision, and mental health treatments and hearing examinations received while the child(ren) are in the foster home.

b. School reports including report cards and pictures.

c. Date the child(ren) left the placement.

d. Name, address, and telephone number of the person to whom the child(ren) are discharged.

113.10(2) *Confidentiality.* Foster parents shall maintain confidentiality regarding the child(ren) in placement except as required to comply with rules on mandatory reporting of child abuse and with the child(ren)'s case permanency plan. Foster parents shall not without parent or guardian and department consent post pictures or information concerning the child(ren) on any Internet website or on social media.

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.11(237) Health of foster family.

113.11(1) *Health report required.* The foster parents shall furnish the licensing agency with a health report on the family completed no more than six months before the application for licensure. The report shall include information on all family members, including foster parents, their minor child(ren) who reside in the home, and adult household members. An updated report shall be provided upon request of the department licensing worker or the recruitment and retention contractor.

113.11(2) *Contents of report.* This report shall include a statement from an impartial health practitioner that there are no physical or mental health problems which would be a hazard to the child(ren) placed in the home and a statement that the foster parents' health would not prevent needed care from being provided to the child(ren).

113.11(3) *Whooping cough vaccine.* All adult household members who are caregivers must have up-to-date whooping cough vaccines unless contrary to the person's health or sincerely held religious belief.

113.11(4) *Exemption from whooping cough vaccine.* Nothing in this rule shall be construed to require the whooping cough vaccine for adult household members who are a member of a church or religious organization which is against vaccinations. In such instance, a notarized statement from the household member shall be incorporated into the health record.

113.11(5) *Capability for caring for the child(ren).* If there is evidence that the foster parent is unable to provide necessary care for the child(ren), the department licensing worker, the recruitment and retention contractor, or the physician may require additional medical and mental health reports, including a substance abuse evaluation.

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5064C**, IAB 7/1/20, effective 9/1/20; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.12(237) Characteristics of foster parents.

113.12(1) *Age.*

a. Foster parents shall be at least 21 years of age.

b. The age of foster parents shall be considered as it affects their ability to care for a specific child and function in a parental role.

113.12(2) *Income and resources.* The foster family shall have sufficient income and resources to provide adequately for the family's own needs.

113.12(3) *Religious considerations.* The foster parent shall respect the child(ren)'s religious background and affiliation.

113.12(4) *Requirements of foster parents.* Foster parents shall be stable, responsible, physically able to care for the type of child(ren) placed, mature individuals who are not unsuited by reason of substance abuse, lewd or lascivious behavior or other conduct likely to be detrimental to the physical or mental health or morals of the child(ren). They shall exercise good judgment in caring for the child(ren) and have a capacity to accept agency supervision.

113.12(5) *Personal characteristics.* The foster parents shall:

a. Provide evidence of relationship stability.

b. Have realistic expectations of the child(ren).

c. Have time available to parent the child(ren).

d. Be able to communicate with the licensing agency and health care and other service providers.

e. Have functional literacy, a level of reading, writing and calculation skills such as having the ability to read labels on medications in order to properly administer them.

f. Be able to accept and deal with acting out behavior with realistic expectations and good judgment.

g. Include the child(ren) in normal family life.

h. Have the ability to be accepting and loving toward the child(ren) entering the home.

i. Be able to support the case permanency plan for the child(ren) and be willing to cooperate with visits, transportation, or other activities that support the child(ren)'s connection to and reunification with the child(ren)'s family.

j. Ensure that all family members are aware of having the child(ren) in the home.

k. Articulate their strengths and concerns and limitations which are essential to the department's matching the child(ren) with foster parents appropriately.

113.12(6) *Determination of characteristics.* The areas discussed in subrules 113.12(4) and 113.12(5) shall be explored through observation of the family and interviews with family members and documented in a foster home study as described in subrule 113.3(4), or in the foster family record when explored after licensure and prior to renewal. Any additional areas that the family or worker identifies as a possibility for creating problems shall also be documented in the foster family record.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5064C**, IAB 7/1/20, effective 9/1/20; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.13(237) Record checks. Record checks are required for each foster parent applicant and for anyone who is 14 years of age or older living in the home of the applicant. The purpose of the record checks is to determine whether any of these persons has any founded child abuse or dependent adult abuse reports or criminal convictions or has been placed on the sex offender registry.

113.13(1) *Procedure.* The department's contractor for the recruitment and retention of resource families shall assist applicants in completing required record checks, including fingerprinting.

a. Iowa records. Each foster parent applicant and anyone who is 14 years of age or older living in the home of the applicant shall be checked for records with:

(1) The Iowa central abuse registry, using Form 470-0643;

(2) The Iowa division of criminal investigation, using Form 595-1396;

(3) The Iowa sex offender registry; and

(4) Iowa Courts Online.

b. Other records.

(1) Each foster parent applicant and any other adult living in the household shall also be checked for records on the child abuse registry of any state where the person has lived during the past five years.

(2) Each foster parent applicant shall also be fingerprinted for a national criminal history check. Fingerprinting, for the purpose of a national criminal history check, is required on all other adult household members at the time of initial application effective with applications dated on or after October 1, 2011. When warranted, the department may require fingerprinting for a national criminal history check on adult household members who move in after initial application.

113.13(2) *Evaluation of record.* If the applicant or anyone living in the home has a record of founded child or dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall not license the applicant as a foster family unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of license.

a. Exclusion. An evaluation shall not be performed if the person has been convicted of:

(1) A felony offense as set forth in Iowa Code section 237.8(2)*"a"*(3); or

(2) A crime in another state that would be a felony as set forth in Iowa Code section 237.8(2)*"a"*(3).

b. Scope. The evaluation shall consider the nature and seriousness of the founded child or dependent adult abuse or crime in relation to:

(1) The position sought or held,

(2) The time elapsed since the abuse or crime was committed,
(3) The circumstances under which the crime or founded abuse was committed,
(4) The degree of rehabilitation,
(5) The likelihood that the person will commit the abuse or crime again, and
(6) The number of abuses or crimes committed by the person.

c. Evaluation form. The person with the founded child or dependent adult abuse or criminal conviction report shall complete and return Form 470-2310 within ten calendar days of the date of receipt to be used to assist in the evaluation. Failure of the person to complete and return Form 470-2310 within the specified time frame shall result in denial of licensure.

113.13(3) *Evaluation decision.* Centralized service area staff or designee shall conduct the evaluation and make the decision. The department shall issue Form 470-2310 to inform the subject of the decision and describe the basis of the decision using the criteria specified in paragraph 113.13(2)*"b."* The department shall mail the form to the person on whom the evaluation was completed:

a. Within 30 days of receipt of the completed Form 470-2310, or

b. When the person whose record is being evaluated fails to complete the evaluation form within the time frame specified in paragraph 113.13(2)*"c."*

113.13(4) *License renewal.* Foster parents applying for an annual or biennial license renewal shall be subject to the same checks as new applicants, except for fingerprinting. The department shall evaluate only abuses and convictions of crimes that occurred since the last record check. The evaluation shall be conducted using the same process.

This rule is intended to implement Iowa Code section 237.8(2).

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.14(237) Reference checks.

113.14(1) At least three additional unsolicited references shall be checked for all foster family home applicants in addition to a minimum of three references provided by the applicant. Required references shall include a minimum of one relative and one nonrelative.

113.14(2) Responses of references shall be documented in the applicant's record.

113.14(3) Information received from references may be discussed with the applicant at the discretion of the worker. The reference shall be so informed.

113.14(4) Reference checks shall include only those areas related to the applicant's ability to care for children and should include discussion of the following areas:

a. How long and in what capacity the reference has known the applicant.

b. Personal qualities of the applicant including the general character, ability to get along with others, ability to deal with the child(ren)'s problem behavior, ability to give affection and care, discussion of use of drugs and alcohol, and questions regarding personal difficulties that could be detrimental to the child(ren).

c. Relationship stability.

d. How the applicant handles anger, problems, crisis situations, discipline, and disappointments.

e. Any areas of general concern not previously mentioned.

f. Would the reference feel comfortable leaving the child(ren) in this home for a period of time?

g. Recommendations regarding licensing.

113.14(5) When warranted, additional references may be sought after licensure.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5064C**, IAB 7/1/20, effective 9/1/20; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.15(237) Unannounced visits.

113.15(1) The department's recruitment and retention contractor shall make unannounced visits during periods of the day when the child(ren) and foster parents would normally be at home and awake, unless there has been a specific complaint about the family and care of the child(ren).

113.15(2) The unannounced visit shall include, but is not limited to, assessment of the following areas:

a. Home environment.

b. Who was present at the time of the visit.

c. Interaction between the child(ren) and foster family and their child(ren).

d. The child(ren)'s perception of the foster parents, other child(ren) and adults in the home, behavioral expectations of foster parents, discipline used by foster parents, religious training, school, contact with natural parents, and purpose of placement in foster care.

e. The foster parents' view of the child(ren), the child(ren)'s problem, placement worker's involvement, plan for the child(ren), involvement of biological parents, and additional services that either the child(ren) or foster parents need.

f. Any previously or currently cited deficiencies, corrective action plans and progress.

g. Any previous or current concerns from department workers.

h. Discussion of placements during the licensing year and, if none, the reason why.

i. Progress on completing training in the foster parents' training plan.

j. Awareness of the foster parents' license capacity and compliance.

k. Recommended action.

113.15(3) An unannounced visit to the foster home:

a. Shall be completed annually;

b. Shall not be waived; and

c. Shall not occur in conjunction with license renewal.

113.15(4) The findings from the unannounced visit shall be summarized on Form 470-5438.

a. The report shall be sent to the department licensing worker and the foster parents within two weeks after the visit.

b. A copy of the report shall be retained in the foster parents' record.

113.15(5) Actions after the unannounced visit.

a. When deficiencies are cited that do not appear likely to cause immediate physical or mental harm to the child(ren), an additional visit may be scheduled. The department licensing worker and the recruitment and retention contractor shall discuss the deficiencies with the foster parents and make plans for improving the deficiencies.

b. When the reported deficiencies raise questions of concern as to the quality of care provided, the recruitment and retention contractor shall:

(1) Report deficiencies to the department licensing worker and to the placement worker for any child(ren) currently placed in the home;

(2) Hold a meeting with the department licensing worker and the foster parents to discuss deficiencies and the plans for improving the deficiencies and then complete a written corrective action plan as to how the foster parents intend to address the deficiencies.

c. When the reported deficiencies appear likely to cause immediate physical or mental harm to the child(ren), the service area manager or designee shall immediately:

(1) Direct the placement worker to determine if the child(ren) should be removed, and

(2) Direct the licensing worker to complete a review of the foster home to determine if the family should continue to be licensed, should receive a provisional license, or should have the license revoked according to 441—112.6(237).

113.15(6) When the foster parents refuse to make a written commitment to improve the deficiencies, the department licensing worker shall conduct a complete review of the foster home to determine if the license should be revoked according to rule 441—112.6(237).

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.16(237) Planned activities and personal effects.

113.16(1) *Daily routine.* The daily routine shall promote good health and provide an opportunity for activity suitable for the child(ren) with time for rest and play.

113.16(2) *Clothing.*

a. Any child(ren) should have their own clothing.

b. Any child(ren) shall have training and help in selection and proper care of clothing.

c. Clothing shall be suited to the existing climate and seasonal conditions.

d. Clothing shall be becoming, of proper size, and culturally appropriate.

e. There shall be an adequate supply of clothing to permit laundering, cleaning and repair.

f. There shall be adequate closet and drawer space for the child(ren) to permit access to their clothing.

113.16(3) *Educational opportunity.* Every child shall be given the opportunity to complete high school or vocational training in accordance with the child's case permanency plan. The foster parent shall be an advocate for the child(ren) by working with the child(ren)'s school.

113.16(4) *Religion and culture.* Each child shall be given an opportunity, in consultation with the child's parents, to participate in the child's culture and religion. The child(ren) shall not be required to participate in religious training or observances contrary to the wishes of the biological or adoptive family or the religious beliefs of the child(ren).

113.16(5) *Community participation.* Every child shall be given the opportunity to develop healthy social relationships through participation in neighborhood, school and other community and group activities. The child(ren) shall have the opportunity to invite friends to the foster home and to visit the home of friends.

113.16(6) *Work assignments.* Work assignments shall be in keeping with the child(ren)'s age and development.

a. Exploitation of the child(ren) is prohibited. No child(ren) shall be permitted to do any hazardous tasks or to engage in any work which is in violation of the child labor laws of the state.

b. The child(ren) shall have the opportunity to learn to assume some responsibility for self and for household duties in accordance with the child(ren)'s age, health and ability. However, assigned tasks shall not deprive the child(ren) of school, sleep, play or study periods.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.17(237) Medical examinations and health care of the child(ren).

113.17(1) *Medical and dental care.* Foster parents shall keep the child(ren)'s department case manager informed of any medical and dental appointments and treatments prescribed for the child(ren).

a. Foster parents shall contact the child(ren)'s parents to engage them in the process of accessing routine medical and dental care for their child(ren) unless parental rights have been terminated.

b. In case of an emergency or urgent situation requiring medical care and treatment of an acute illness, disease or condition of the child(ren), when a delay or inability to access parental or department consent for medical care or treatment would endanger the health or physical well-being of the child(ren), the foster parents can provide consent for medical care and treatment.

113.17(2) *Exemption from medical care.* Nothing in this rule shall be construed to require medical treatment or immunization for a minor child of any person who is a member of a church or religious organization which is against medical treatment for disease. In such instance, an official statement from the organization and a notarized statement from the parents shall be incorporated in the record. In potentially life-threatening situations, the child's care shall be referred to appropriate medical and legal authorities.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.18(237) Training and discipline of child(ren).

113.18(1) *Foster parents' methods of training and discipline.* The home study evaluation of each foster parent applicant shall include a discussion and a written report of the foster parents' methods of training and discipline. Discipline shall be designed to help the child(ren) develop self-control, self-esteem, and respect for the rights of others.

113.18(2) *Restrictions on training and discipline.* Training and discipline of the child(ren) shall be handled with kindness and understanding.

a. The child(ren) shall not be locked in a room, closet, box, or other device.

b. No child(ren) shall be deprived of food as punishment.

c. No child(ren) shall be subjected to verbal abuse, threats or derogatory remarks about the child(ren) or the child(ren)'s family.

d. The use of corporal punishment is prohibited.

e. Restraints shall not be used as a form of discipline.

(1) Reasonable physical force may be used to restrain the child(ren) only in order to prevent injury to the child(ren), injury to others, the destruction of property, or extremely disruptive behavior.

(2) Upon approval of the department, the foster parent may use restraints only in accordance with the written plan of a licensed mental health professional who is working with the child(ren) and the foster parents.

113.18(3) *Reports of mistreatment.* Reports of mistreatment coming to the attention of the department licensing worker and caseworker for the child(ren) shall be investigated promptly and referred to the proper authorities when necessary.

This rule is intended to implement Iowa Code sections 234.40 and 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.19(237) Emergency care and release of child(ren).

113.19(1) *Supervision and arrangements for emergency care.*

a. Foster parents shall provide supervision of the child(ren) in preadoptive placement as dictated by the individual child's specific needs.

b. In case of emergency requiring the foster parents' temporary absence from the home, arrangements shall be made with other licensed foster parents or with designated, responsible persons for the care of the child(ren) during the period of absence. The child(ren)'s placement worker shall be notified of all emergency absences of the foster parents.

113.19(2) *Release of child(ren).* The foster parents shall release the child(ren) only to the agency, parent or guardian from whom the child(ren) were received for care, or the person specifically designated by the agency, parent or guardian.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

441—113.20(237) Changes in foster family home. Foster parents shall notify the department and the recruitment and retention contractor within seven working days of:

1. Any change in the number of persons living in the home (except for the child(ren) placed in the home);
2. A move to a new home; or
3. Any circumstances in the home that could negatively affect the health, safety or welfare of the child(ren) in the family's care.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 6961C**, IAB 4/5/23, effective 6/1/23]

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◊ Two or more ARCs

CHAPTER 114
LICENSING AND REGULATION OF ALL GROUP LIVING FOSTER CARE FACILITIES FOR CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 114]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

441—114.1(237) Applicability. This chapter outlines the basic standards for all group living foster care facilities and contains the basic standards applicable to community residential facilities for children. Additional standards applicable to specific levels of group living are discussed in 441—Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," and 441—Chapter 116, "Licensing and Regulation of Residential Facilities for Children with an Intellectual Disability or Brain Injury."

[**ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.2(237) Definitions.

"Adequate lighting" means a light intensity of 20 foot-candles (approximately equivalent to a 60 watt bulb at a clear distance of 5 feet).

"Caseworker" means any staff of the facility who is primarily responsible for planning for individual children, a family, or groups, as well as coordination with referral sources and coordination of services to the individual.

"Casework supervisor" means any staff of the facility who provides supervision of the caseworker(s) by regularly scheduled face-to-face case specific discussions with the caseworker.

"Chemical restraint" means the use of chemical agents including psychotropic drugs as a form of restraint. The therapeutic use of psychotropic medications as a component of a service plan for a particular child is not considered chemical restraint.

"Child care worker" means any staff of the facility whose primary responsibility is the direct care of children in the facility.

"Community residential facility" means a facility which provides care for children who are considered unable to live in a family situation due to social, emotional or physical disabilities but are capable of interacting in a community environment with a minimum amount of supervision. The facility provides 24-hour care including board and room. Community resources are used for education, recreation, medical, social and rehabilitation services. The facility is responsible for planning the daily activities of the children, discipline, guidance, peer relationships, and recreational programs.

"Control room" means a locked room used for treatment purposes in a comprehensive residential facility.

"Educational degrees" means formally approved certificates from accredited schools.

"Immediate family," for the purposes of this chapter, means persons who have a blood or legal relationship with the child.

"Mechanical restraint" means restriction by the use of a mechanical device of a child's mobility or ability to use the hands, arms, or legs.

"Physical restraint" means direct physical contact required on the part of a staff member to prevent a child from hurting self, others, or property.

"Private juvenile detention home" means a juvenile detention home as defined in Iowa Code section 232.2, which does not meet the requirements of being "county or multicounty" as defined in rule 441—105.1(232).

"Private juvenile shelter care home" means a juvenile shelter care home as defined in Iowa Code section 232.2, which does not meet the requirements of being "county or multicounty" as defined in rule 441—105.1(232).

"Prone restraint" means a physical restraint in which a child is held face down on the floor.

"Protective locked environment" means the same as defined in Iowa Code section 237.1(17).

"Schedule II medications" means those controlled substances identified in Iowa Code chapter 124.

"Staff" means any person providing care or services to or on behalf of the residents whether the person is an employee of the facility, an independent contractor or any other person who contracts with the facility, an employee of an independent contractor or any other person who contracts with the facility, or a volunteer.

"Time out" means the temporary and short-term restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control. Staff physically preventing the resident from leaving the time out area would be considered seclusion in control room conditions.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23; **ARC 0109D**, IAB 3/4/26, effective 5/1/26]

441—114.3(237) Physical standards. Local building and zoning ordinances shall be met.

114.3(1) *Grounds.*

a. An outdoor play area of 75 square feet per child shall be provided.

b. The play area shall be identified and kept free from hazards that could cause injury to a child.

c. Rubbish and trash shall be kept separated from the play area.

d. The grounds shall be adequately drained.

114.3(2) *Buildings.*

a. All living areas shall:

(1) Have screens on windows used for ventilation.

(2) Be maintained in clean, sanitary conditions, free from vermin, rodents, dampness, noxious gases and objectionable odors.

(3) Be in safe repair.

(4) Provide for adequate lighting when natural sunlight is inadequate.

(5) Have heating and storage areas separated from sleeping or play areas.

(6) Have walls and ceiling surfaced with materials that are asbestos free.

b. All sleeping rooms shall:

(1) Provide a minimum of 60 square feet per child for multiple occupancy.

(2) Provide a minimum of 80 square feet per child for single occupancy.

(3) Not sleep more than four children per room. Facilities licensed prior to July 1, 1981, meeting current square footage requirements shall be allowed to house five children per room.

(4) Be of finished construction.

Facilities licensed prior to July 1, 1981, having a square foot area less than that required in subparagraphs (1) and (2) shall be considered to meet those standards.

c. All rooms aboveground shall:

(1) Have a ceiling height of at least 7 feet, 6 inches.

(2) Have a window area of at least 8 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

d. All rooms belowground shall:

(1) Have a ceiling height of at least 6 feet, 8 inches.

(2) Have a window area of at least 2 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

(3) Have floor and walls constructed of concrete or other materials with an impervious finish and free from groundwater leakage.

114.3(3) *Bedrooms.*

a. Each child in care shall have a solidly constructed bed.

b. Sheets, pillowcases, and blankets shall be provided for each child and shall be kept clean and in good repair.

c. Each child in care shall have adequate storage space for private use, and a designated space for hanging clothing in proximity to the bedroom occupied by the child.

d. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

114.3(4) *Heating.*

a. The heating unit shall be located and operated to maintain the temperature in the living quarters at a minimum of 65 degrees Fahrenheit during the day and 55 degrees Fahrenheit during the night. Variances may be made in case of health problems. Temperature is measured at 24 inches above the floor in the middle of the room.

b. All space heaters and water heaters involving the combustion of fuel, such as gas, oil or similar fuel, shall be vented to the outside atmosphere.

c. Neither rubber nor plastic tubing shall be used as supply lines for gas heaters.

d. The heating or cooling plant shall be checked at least annually and kept in safe working condition at all times.

[**ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.4(237) Sanitation, water, and waste disposal.

114.4(1) *Bathroom facilities.*

a. Bathrooms shall have an adequate supply of hot and cold running water.

b. Each bathroom shall be properly equipped with toilet tissue in dispensers, paper towels or functional hand dryers, soap, and other items required for personal hygiene.

c. Toilets and baths or showers shall provide for individual privacy.

d. There shall be a shower or tub for each ten children or portion thereof.

e. Tubs and showers shall have slip-proof surfaces.

f. At least one toilet and one wash basin shall be provided for each six children or portion thereof.

g. Toilet facilities shall be provided with natural or artificial ventilation capable of removing odors and moisture.

h. Toilet facilities adjacent to a food preparation area shall be separated completely by an enclosed solid door.

i. All toilet facilities shall be kept clean.

j. When more than one stool is used in one bathroom, partitions providing privacy shall be used.

k. Toilets, wash basins, and other plumbing or sanitary facilities shall be maintained in good operating condition.

114.4(2) *Food preparation and storage.*

a. Cracked dishes and utensils shall not be used in the preparation, serving, or storage of food.

b. Storage areas for perishable foods shall be kept at 45 degrees Fahrenheit or below.

c. Storage areas for frozen foods shall be kept at zero degrees Fahrenheit or below.

d. Food that is to be served hot shall be maintained at 140 degrees Fahrenheit or above.

e. Food that is to be served cold shall be maintained at 45 degrees Fahrenheit or below.

f. The kitchen and food storage areas shall be kept clean and neat. Foods shall not be stored on the floor.

g. The floor and walls shall be of smooth construction and in good repair.

114.4(3) *Personnel handling food.* Personnel who handle food shall:

a. Be free of infection.

b. Be clean and neatly groomed.

c. Wear clean clothes.

d. Not use tobacco in any form while preparing or serving food.

114.4(4) *Dishwashing facilities.*

a. Manual dishwashing will be allowed in facilities that normally serve 15 or less people at one meal.

b. Commercial dishwashers shall be used in facilities serving more than 15 people at one meal, and shall meet the following criteria:

(1) When chemicals are added for sanitation purposes, they shall be automatically dispensed.

(2) Machines using hot water for sanitizing must maintain wash water at least 150 degrees Fahrenheit and rinse water at a temperature of at least 180 degrees Fahrenheit or a single temperature machine at 165 degrees Fahrenheit for both wash and rinse.

(3) All machines shall be thoroughly cleaned and sanitized at least once each day or more often if necessary to maintain satisfactory operating condition.

c. Soiled and clean dish table areas shall be of adequate size to accommodate the dishes for one meal.

d. All hand-held food preparation and serving equipment shall be cleaned and sanitized following each meal. Dispensers, urns, and similar equipment shall be cleaned and sanitized daily.

114.4(5) *Foods not prepared at site of serving.*

a. The place where food is prepared for off-site serving shall conform with all requirements for on-site food preparation.

b. Food shall be transported in covered containers or completely wrapped or packaged so as to be protected from contamination.

c. During transportation, and until served, hot foods shall be maintained at 140 degrees Fahrenheit or above and cold food maintained at 45 degrees Fahrenheit or below.

114.4(6) *Milk supply.* When fluid milk is used, it shall be pasteurized Grade A.

114.4(7) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system.

114.4(8) *Private water supplies.* Any facility that serves at least 25 people for at least 60 days during the year and is supplied by its own well meets the definition of a public water supply and must be regulated by the department of natural resources.

a. Maintenance and operation. Each privately operated water supply shall be maintained and operated in a manner that ensures safe drinking water. Each water supply used as part of a facility shall be annually inspected and evaluated for deficiencies that may allow contaminants access to the well interior. Items such as open or loose well caps, missing or defective well vents, poor drainage around the wells, and the nearby storage of potential contaminants shall be evaluated. All deficiencies shall be corrected within 30 days of discovery by a well contractor certified by the state.

b. Evaluation and water testing. As part of the inspection and evaluation, water samples shall be collected and submitted by the local health sanitarian or a well contractor certified by the state to the state hygienic laboratory or other laboratory certified for drinking water analysis by the department of natural resources. The minimum yearly water analysis shall include coliform bacteria and nitrate (NO3-) content. Total arsenic testing shall be performed once every three years. The water shall be deemed safe when there are no detectible coliform bacteria, when nitrate levels are less than 10 mg/L as nitrogen, and when total arsenic levels are 10 µg/L or less. A copy of the laboratory analysis report shall be provided to the department within 72 hours of receipt by the water supply.

c. Multiple wells supplying water. When the water supply obtains water from more than one well, each well connected to the water distribution system shall meet all of the requirements of these rules.

d. Deficiencies. When no apparent deficiencies exist with the well or its operations and the water supply is proven safe by meeting the minimum sampling and analysis requirements, water safety requirements have been met. Wells with deficiencies that result in unsafe water analysis require corrective actions through the use of a well contractor certified by the state.

e. When water is proven unsafe. When the water supply is proven unsafe by sampling and analysis, the facility shall immediately provide a known source of safe drinking water for all water users and hang notification at each point of water use disclosing the water is unsafe for drinking water uses. In addition, the facility shall provide a written statement to the department disclosing the unsafe result and detail a plan on how the water supply deficiencies will be corrected and the supply brought back into a safe and maintained condition. The statement shall be submitted to the department within ten days of the laboratory notice. All corrective work shall be performed and the water supply sampled and analyzed again within 45 days from any water test analysis report that indicates the water supply is unsafe for drinking water uses.

f. Water obtained from another source through hauling and storage must meet the requirements of the department of natural resources.

114.4(9) *Heating or storage of hot water.* Each tank used for the heating or storage of hot water shall be provided with a pressure and temperature relief valve.

114.4(10) *Sewage treatment.*

a. Facilities shall be connected to public sewer systems where available.

b. Private disposal systems shall be designed, constructed, and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

114.4(11) *Garbage storage and disposal.*

a. A sufficient number of garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly tight, leakproof, and rodent proof and shall be maintained in a sanitary condition.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.5(237) Safety.

114.5(1) *General.* Facilities shall take sufficient measures to ensure the safety of the children in care in all of their programs.

114.5(2) *Premises.*

a. Stairways, halls and aisles shall be of substantial nonslippery material, shall be maintained in a good state of repair, shall be adequately lighted and shall be kept free from obstructions at all times. All stairways shall have handrails.

b. Radiators, registers, and steam and hot water pipes shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

c. Fuse boxes and circuit breakers shall be inaccessible to children.

d. Facilities shall have written procedures for the handling and storage of hazardous materials.

e. Firearms and ammunition shall be kept under lock and key and inaccessible to children. When firearms are used, the facility shall have written policies regarding their purpose, use, and storage.

f. All swimming pools shall conform to state and local health and safety regulations. Adult supervision shall be provided at all times when children are using the pool.

g. The facility shall have policies regarding fishing ponds, lakes, or any bodies of water located on or near the facility grounds and accessible to the children.

114.5(3) *Emergency evacuation and safety procedures.* Upon admission all children shall receive instruction regarding evacuation and safety procedures. All living units utilized by children shall have a posted plan for evacuation and safety procedures regarding severe weather events, fire or other natural or man-made disasters. Practice fire drills shall be held monthly, and severe weather drills shall be held twice annually.

114.5(4) *Fire inspection.* Each facility shall procure an annual fire inspection approved by the state fire marshal and shall meet the recommendations thereof.

114.5(5) *Local codes.* Each facility shall meet local building, zoning, sanitation and fire safety ordinances. Where no local standards exist, state standards shall be met.

114.5(6) *Safety, protection, and well-being of children in care.* Facilities shall develop and follow written policies and procedures that assure the safety, protection, and well-being of children in care. Policies shall address, but not be limited to, the following:

a. Supportive leadership of the facility that promotes protecting each child from abuse or bullying from other children and staff.

b. Defining the facility's culture to reduce the use of unnecessary restraint.

c. Clear definitions of unsafe behavior and the emergency situations when it is appropriate to use physical interventions.

d. Staff training and development that give staff confidence they are supported by leadership with proper supervision and ongoing access to information about best practices and evidence-based approaches to care.

e. Adequate supervision of children while the children are using any hazardous or dangerous objects or equipment and when children are using the Internet or other social media.

f. The social, cultural, and developmental needs of children in care.

g. Providing personal care items to children in care. Personal care items must be provided to the children in care and must reflect the individual, cultural, racial and ethnic needs of the youth living in the facility's programs.

[**ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.6(237) Organization and administration. Any change in the name of the facility, the address of the facility, the executive, or the capacity shall be reported to the department.

114.6(1) *Table of organization.* A table of organization including the identification of lines of responsibility and authority from policymaking to service to clients shall be available to the licensing staff.

114.6(2) *Purpose of agency or facility.* The purpose or function of the organization shall be clearly defined in writing and shall include a description of the children to be accepted for care and the services offered.

114.6(3) *Governing bodies or individuals.* All group living foster care facilities shall:

a. Have a governing board or individuals who are accountable for and have authority over the policies and activities of the organization. In the case of an organization owned by a proprietor or partnership, the proprietor or partner shall be regarded as the governing body.

b. Provide the department with a list of names, addresses, telephone numbers and titles of the members of the governing body.

c. Have adequate insurance covering fire and liability as a protection to children in care.

d. For organizations with the home base located outside Iowa, have duly authorized representatives with decision-making abilities designated within the state of Iowa.

114.6(4) *Executive director.* The governing body or proprietor or partner(s) shall select and appoint an executive director with full administrative responsibility and qualifications for carrying out the policies, procedures and programs established by the governing body.

114.6(5) *Financial solvency of facilities.* Profit and nonprofit institutions shall maintain financial solvency to ensure adequate care of children and youth for whom responsibility is assumed. It shall have sufficient financial resources, predictable income, or both, and not be totally dependent upon current fees, for a three-month operating period. The facility shall have written policies and procedures describing the program of the facility and specifying how it will be carried out.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.7(237) Policies and record-keeping requirements.

114.7(1) *Policies in writing.* The following current personnel policies and practices of the agency and relating to the specific facility shall be described in writing and accessible to staff upon request:

a. Affirmative action and equal employment opportunity policies and procedures covering the hiring, assignment, and promotion of employees.

b. Job descriptions for all positions.

c. Provisions for vacations, holidays, and sick leave.

d. Effective, time-limited grievance procedures allowing the aggrieved party to bring the grievance to at least one level above that party's supervisor.

e. Authorized procedures, consistent with due process, for the suspension and dismissal of an employee for just cause.

f. Written procedures for annual employee evaluations.

114.7(2) *Health of staff.* Each staff person who has direct client contact or is involved in food preparation shall be tested for tuberculosis and have a physical examination within six months prior to hiring, unless the staff can produce valid documentation of the physical and tuberculosis test from within the previous three years. Physical examinations shall be completed every three years thereafter. Evidence of these examinations or tests shall be included in each personnel file. The examinations or tests shall be completed by one of the following:

a. A physician as defined in Iowa Code section 135.1(4);

b. An advanced registered nurse practitioner who is registered with and certified by the Iowa board of nursing to practice nursing in an advanced role; or

c. A physician assistant licensed under Iowa Code chapter 148C.

114.7(3) *Staff records.*

a. The facility shall maintain the following information with respect to each staff person:

(1) Name and current address of each staff person.

(2) At least two written references or documentation of oral references. In case of unfavorable references, there shall be documentation of further checking to ensure that the person will be reliable.

(3) Documentation of all record checks and evaluations as required in subrule 114.24(1).

(4) A written, signed and dated statement furnished by the staff person prior to providing any care or services to or on behalf of the facility which discloses any founded reports of child abuse on the person that may exist.

(5) Reserved.

(6) Records of a physical examination or a record of a health report, as required in subrule 114.7(2), plus a written record of subsequent health services rendered to staff necessary to ensure that each individual is physically able to perform the job duties or functions.

(7) Reserved.

(8) Records of training sessions attended, including dates and content of the training.

(9) When otherwise required in situations that apply, a certified copy of a school transcript, diploma, or written statement from the school or supervising agency for positions having educational requirements.

b. In addition, with respect to staff who are employed by the facility, the facility shall maintain the following records:

(1) Social security number of each employee.

(2) A job application containing sufficient information to justify the initial and current employment.

(3) A certified copy of a school transcript, diploma, or written statement from the school or supervising agency before permanent employment of applicants for positions having educational requirements.

(4) Written verification of licensure before permanent employment of applicants for positions requiring licenses. Evidence of renewal of licenses as required by the licensing agency.

(5) Current information relative to work performance evaluation.

(6) Information on written reprimands or commendations.

(7) Information on position in the agency and date of employment.

(8) If the applicant, probationary employee or temporary employee has completed and submitted Form 470-2310 to the agency, a copy shall be kept in the staff record.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.8(237) Staff.

114.8(1) *Qualifications of staff.*

a. A caseworker shall have graduated from a four-year college or university with a bachelor's degree in a human services field related to social work, psychology or a related behavioral science or in education and the equivalent of one year of full-time experience in social work or in the delivery of human services in a public or private agency, or six years of supervised child welfare experience in residential care or a combination of advanced education in the behavioral sciences and experience equal to six years.

b. A casework supervisor shall have either a master's degree in social work with one year of supervised experience after the master's degree or a master's degree in psychology or counseling with two years of experience beyond the master's degree, one of which was under supervision. The experience shall be in the area of child welfare services.

c. Child care workers shall be at least 18 years of age.

d. Any licensed facility having persons in employment in positions for which present rules require higher qualifications will be considered to meet rules with the present staff. New staff will need to meet the requirements of these rules.

e. A person who has a record of a criminal conviction or founded child or dependent adult abuse report shall not be employed, unless an evaluation of the crime or founded child or dependent adult abuse has been made by the department which concludes that the crime or founded child or dependent adult abuse does not merit prohibition of employment. If a record of criminal conviction or founded child or dependent adult abuse exists, the person shall be offered the opportunity to complete and submit Form 470-2310. In its evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought, the time elapsed since the commission of the crime or founded abuse, the

circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, and the number of crimes or founded abuses committed by the person involved.

114.8(2) *Number of staff.*

a. Children shall be provided with 24-hour awake supervision. There shall be at least one awake and readily accessible staff person on duty for each currently occupied living unit. The staff person shall make regular visual checks at least every hour throughout the night. A log shall be kept of all checks, including the time of the check and any significant observations. Policies for nighttime checks shall be in writing.

b. Each facility shall have the services of a casework supervisor and a caseworker adequate to fulfill the staff duties.

c. There shall be an on-call system operational 24 hours a day to provide supervisory consultation. There shall be a written plan documenting this system.

d. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to eight staff to client ratio during all times children are awake and present in the facility and during supervised outings.

114.8(3) *Staff duties.*

a. The casework supervisor shall provide in-person case specific supervision at the site of the facility for one hour per month per caseworker and be available for consultation in case of emergency.

b. Caseworkers shall:

(1) Develop a service plan for each child containing goals and objectives with projected dates of accomplishment and shall involve the client, referral agency, and family whenever possible.

(2) Develop a specific plan relating to the involvement of the child's parents unless documented by the caseworker that their involvement would be counterproductive.

c. The facility staff shall be responsible for the following:

(1) Documenting case reassessments quarterly, involving the same personnel as previously involved in service plan development.

(2) Documenting the implementation of the service plan.

(3) Providing for scheduled in-person conferences with each resident.

(4) Providing a supportive atmosphere for the child.

(5) Providing for coordination of internal and external activities of the child.

(6) Providing for liaison with the referring agency.

(7) Providing leadership and guidance to the children.

(8) Providing a mechanism for dealing with day-to-day program operations.

(9) Being responsible for overseeing and maintaining general health and well-being of children.

(10) Supervising the living activities of the children.

(11) Monitoring and recording behavior on a daily basis.

(12) At all times, knowing where the children are and where they are supposed to be to assure ongoing safety.

114.8(4) *Staff development.* Staff development shall be appropriate to the size and nature of the facility. There shall be a written format for staff training that includes:

a. Orientation for all new employees to acquaint them with the philosophy, organization, program practices, and goals of the facility.

b. Training of new employees in areas related to their job assignments.

c. Provisions for all staff members to improve their competency. This may be accomplished through such means as:

(1) Attending staff meetings.

(2) Attending seminars, conferences, workshops and institutes.

(3) Visiting other facilities.

(4) Access to consultants.

(5) Access to current information and evidence-based practices relevant to the facility's services.

d. An individual designated responsible for staff development and training, who will complete a written staff development plan which shall be updated annually.

114.8(5) *Volunteers.* A facility that utilizes volunteers to work directly with a particular child or group of children shall have a written plan for using volunteers. This plan shall be given to all volunteers. The plan shall indicate that all volunteers shall:

a. Be directly supervised by a paid staff member.

b. Be oriented and trained in the philosophy of the facility and the needs of children in care, and methods of meeting those needs.

c. Be subject to character, reference, and record check requirements described in subrule 114.24(1).

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.9(237) Intake procedures.

114.9(1) *Intake policies.* The agency shall have written intake policies specific to the licensed facility.

114.9(2) *Basis of acceptance.* Children shall be accepted for care only after the following criteria have been met:

a. An assessment of the child's need for service and supervision has been agreed upon by the staff of the facility and the referring agency worker. The child, the child's family, and any other significant people shall be invited to participate in this process to the fullest extent possible.

b. The assessment indicates that the child requires the care offered by this type of facility and is likely to benefit from the program the facility offers.

114.9(3) *Referral information.* The following information shall be made available prior to any decision being made regarding the acceptance of a child. The following information shall be requested by the facility if not yet received.

a. A current social history.

b. A copy of the child's physical assessment including immunization history completed within one year prior to application, when available.

c. Where indicated, or when available, psychological testing completed no more than one year prior to referral.

d. Current educational data.

e. When indicated or available, psychiatric report completed no more than one year prior to referral.

f. Referring agency's case plan which includes goals and objectives to be achieved during placement with a time frame for the achievement of these goals and objectives.

g. Documentation of the legal status of the child which includes any court orders or statements of custody and guardianship.

114.9(4) *Admission requirements.*

a. The following items shall be secured upon admission of the child to the facility.

(1) A placement agreement for the child signed by the person having legal responsibility for the child and the agency where the child is being placed. When this is not available at the time of placement, it shall be furnished within 48 hours of placement in the facility.

(2) Emergency medical authorization from the court, the parents, the guardian, or custodian.

b. The following items shall be provided to the child, the child's family or guardian, and the referring worker at the time of placement:

(1) A description of the services provided.

(2) Written policies regarding children's rights as in rule 441—114.13(237).

(3) Written policies regarding religion, work or vocational experiences, family involvement, and discipline as in rules 441—114.15(237) to 441—114.17(237) and rule 441—114.20(237).

114.9(5) *Personal assessment.* At the time of intake, individual needs will be identified by staff based on written and verbal information from referral sources, observable behavior at intake and the initial interview with youth or family, school contacts, physical examinations, and other relevant material. The individual assessment shall provide the basis for development of a service plan for each child.

114.9(6) *Educational assessment.* An educational assessment shall be developed by the staff and the referring worker. Involvement of the parents or guardian, area education agency, and public schools may be appropriate.

114.9(7) *Person responsible.* Each agency shall designate a person or persons who have the authority to do intake.

114.9(8) *Intake sheet.* An intake sheet shall be completed on each child containing at least the information specified in 114.11(2).

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.10(237) Program services.

114.10(1) *Evaluation services.*

a. When evaluation services are provided by staff of the facility, the services shall be clearly defined so that referral sources are clear about the components of the service.

b. Evaluations shall be based on behavioral observations, social history, educational assessments and shall include an assessment of vocational needs, recreational skills, and physical therapy, speech, language, vision and hearing needs to assist in planning and placement for the child. The need for providing all of these evaluative services will be determined on the basis of the specific child being referred.

114.10(2) *Service plan.* There shall be a written service plan for each child. The service plan shall be based on the individual needs determined through the assessment of each resident, provide for consultation with the family, and shall include the following:

a. Identification of special needs.

b. Description of planned services including measurable goals and objectives which indicate which staff person will be responsible for the specific services in the plan.

c. Indication of where the services are to occur and note the frequency of activities or services.

d. A discharge summary.

114.10(3) *Daily routine.* Each facility shall provide a daily routine for the children in residence which is directed toward developing healthful habits in eating, sleeping, exercising, personal care, hygiene, and grooming according to the needs of the individual child and the living group.

114.10(4) *Daily log.* The facility shall maintain a daily log to generally record noteworthy occurrences regarding the children in care. Problem areas or unusual behavior for specific children shall be recorded in individual children's records.

114.10(5) *Educational services.* An educational program shall be available for each child in accordance with abilities and needs. The educational and teaching standards established by the state department of education shall be met when an educational program is provided within an institution.

114.10(6) *Health care.*

a. There shall be 24-hour emergency and routine medical and dental services available and provided when prescribed. Provisions for these services shall be documented.

b. The facility shall arrange a physical assessment including vision and hearing tests for each child in care within one week of admission unless the child has received an examination within the past year and the results of this examination are available to the facility.

c. A facility shall not require medical treatment when the parent(s) or guardian of the child or the child objects to treatment on the grounds that it conflicts with the tenets and practices of a recognized church or religious denomination of which the parent(s), guardian or child is an adherent. In potentially life-threatening situations, the facility shall refer the child's care to appropriate medical and legal authorities.

d. A facility shall have and staff shall follow written procedures in case of medical emergency.

e. A facility shall schedule a dental examination for each child within 14 days of admission unless the child has been examined within six months prior to admission and the facility has the results of that examination.

114.10(7) *Dietary program.* The facility shall provide properly planned, nutritious and inviting food and take into consideration the dietary and health needs of children. The facility shall follow all dietary recommendations prescribed by medical personnel or a dietitian licensed in the state of Iowa.

114.10(8) *Recreation and leisure programs.*

a. The facility shall provide adequately designed and maintained indoor and outdoor activity areas, equipment, and equipment storage facilities appropriate for the residents it serves. There shall be a variety of activity areas and equipment so that all children can be active participants in different types of individual and group sports and other motor activities.

b. Games, toys, equipment, and arts and crafts material shall be selected according to the ages and number of children with consideration to the needs of the children to engage in active and quiet play.

c. The facility shall plan and carry out efforts to establish and maintain workable relationships with community recreational resources so these resources may provide opportunities for children to participate in community recreational activities.

114.10(9) *Casework services.* A facility shall provide or obtain casework services in the form of counseling in accordance with the needs of each child's individual service plan. Casework services include crisis intervention, daily living skills, interpersonal relationships, future planning and preparation for placement as required by the child.

114.10(10) *Psychiatric and psychological services—(Optional service).*

a. When the diagnostic evaluation of a child indicates need for care by a psychiatrist and under psychiatric guidance, the specialized treatment or consultation shall be provided or arranged by the facility.

b. Psychologists, whose services are used in behalf of children, shall be licensed as a psychologist in the state of Iowa, or be certified by the department of education.

114.10(11) *Volunteers—(Optional service).* Rescinded IAB 12/4/19, effective 1/8/20.

114.10(12) *Liability.* Licensed group living foster care facilities that apply the reasonable and prudent parent standard reasonably and in good faith in regard to a child in foster care shall have immunity from civil or criminal liability which might otherwise be incurred or imposed. This subrule shall not remove or limit any existing liability protection afforded under any other law.

[**ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.11(237) Case files.

114.11(1) *Generally.* All facilities shall establish and maintain case files on each child. The case files shall include the following:

114.11(2) *Face sheet.* The face sheet shall contain the following information:

a. Full name, birth place and date of birth.

b. Parents' full name.

c. Parents' address and telephone number.

d. Religious preference of parents and child.

e. Statement of who has legal custody and guardianship.

f. Name of the referring worker and agency making the referral.

g. Telephone number and address of the agency or court making the referral and contact information of the child's attorney or guardian ad litem.

114.11(3) *Referral packet.* All of the information required in the referral packet shall be contained in the case record including a social history on the child, a copy of the child's physical assessment and immunization history, psychological testing, when available, current educational information, psychiatric report, when available, and the referring agency's case plan.

114.11(4) *Legal documents.*

a. Placement agreement signed by parent(s) or custodian of the child.

b. Petitions and orders of the court regarding adjudication, custody, or guardianship.

114.11(5) *Psychiatric and psychological.* Psychiatric and psychological reports, when available.

114.11(6) *Correspondence.* Correspondence regarding the child.

114.11(7) *Medical.*

a. Medical and surgical authorizations signed by the parent(s), guardian, or contained in the court order.

b. Record of medical care received while in the facility.

c. Information on past medical history.

114.11(8) *School.*

a. Name of school currently attended.

b. Grade placement.

c. Any specific educational problem.

d. Remedial action recommended.

114.11(9) *Service plan.* Individual child service plan, quarterly update, and revisions of the service plan. The service plan shall be updated quarterly or any time upon receipt of a new case permanency plan or juvenile court services plan or as otherwise needed to address the changing needs of the child. Discharge summary completing the service plan information shall be completed upon a child's discharge from placement.

114.11(10) *Documentation.* The following information shall be documented in each child's record.

a. Appropriate notes, all significant contacts with parents, referring worker and other collateral contracts, as well as staff counseling with child and notations on behavior.

b. A summary related to discharge including:

(1) The name, address and relationship of the person or agency to whom the child was released.

(2) The discharge summary (as included in the service plan).

(3) Final disposition of a child's medications as applicable.

(4) Identification of who transported the child and destination postdischarge.

114.11(11) *Electronic records.* An authorized representative of the department shall be provided unrestricted access to electronic records pertaining to the care provided to the residents, who are served as a result of a contract with the department, of the facility.

a. If access to an electronic record is requested by the authorized representative of the department, the facility may provide a tutorial on how to use its particular electronic system or may designate an individual who will, when requested, access the system, respond to any questions or assist the authorized representative as needed in accessing electronic information in a timely fashion.

b. The facility shall provide a terminal where the authorized representative may access records.

c. If the facility is unable to provide direct print capability to the authorized representative, the facility shall make available a printout of any record or part of a record on request in a time frame that does not intentionally prevent or interfere with the department's survey or investigation.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.12(237) Drug utilization and control. The agency shall have and follow written policies and procedures governing the methods of handling prescription drugs and over-the-counter drugs within the facility. No prescription or narcotic drugs are to be allowed in the facility without the authorization of a licensed physician or authorized prescriber.

114.12(1) *Approved drugs.* Only drugs which have been approved by the federal Food and Drug Administration for use in the United States may be used. No experimental drugs may be used.

114.12(2) *Prescribed by physician or other authorized prescriber.* Drugs shall be prescribed by a physician licensed to practice in the state of Iowa or the state in which the physician is currently practicing, or by an advanced registered nurse practitioner or physician assistant as permitted by Iowa law, and may be prescribed only for use in accordance with dosage ranges and indications approved by the federal Food and Drug Administration.

114.12(3) *Dispensed from a licensed pharmacy.* Drugs provided to residents shall be dispensed only from a licensed pharmacy in the state of Iowa in accordance with the pharmacy laws in the Code of Iowa, or from a licensed pharmacy in another state according to the laws of that state, or by a licensed physician.

114.12(4) *Locked cabinet.* All drugs shall be maintained in a locked cabinet. Schedule II medications shall be maintained in a locked box within the locked cabinet. The cabinet key shall be in the possession of a staff person. A bathroom shall not be used for drug storage. A documented exception can be made by persons identified in these rules who may allow self-administered drugs as discussed in subrule 114.12(17).

114.12(5) *Medications requiring refrigeration.* Medications requiring refrigeration shall be kept in a locked box in the refrigerator and separated from food and other items.

114.12(6) *Poisonous or caustic drugs.* All potent poisonous or caustic drugs shall be plainly labeled, stored separately from other drugs in a specific well-illuminated cabinet, closet, or storeroom, and made accessible only to authorized persons.

114.12(7) *Prescribed medications.* All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of the drug, dosage, directions for use and, date of issuing the drug. Medications shall be packaged and labeled according to state and federal guidelines.

114.12(8) *Medication containers.* Medication containers having soiled, damaged, illegible or makeshift labels shall be returned to the issuing pharmacist.

114.12(9) *Medication for discharged residents.* When a resident is discharged or leaves the facility, the facility shall turn over to a responsible agent Schedule II medications and prescription medications currently being administered. The facility may send nonprescription medications with the child as needed. The facility shall document in the child's file:

a. The name, strength, dosage form, and quantity of each medication.

b. The signature of the facility staff person who turned over the medications to the responsible agent.

c. The signature of the responsible agent receiving the medications.

114.12(10) *Unused prescription drugs.* Unused prescription drugs prescribed for residents may not be kept at the facility for more 15 days after the resident has left the facility. The unused prescription drugs shall be destroyed by the facility executive director or the executive director's designee in the presence of at least one witness. Outdated, discontinued, or unusable nonprescription medications shall also be destroyed in a similar manner. The person destroying the medication shall document:

a. The resident's name.

b. The name, strength, dosage form, and quantity of each medication.

c. The date the medication was destroyed.

d. The names and signatures of the witness and staff person who destroyed the medication.

114.12(11) *Refills.* Prescriptions shall be refilled only with the permission of the prescriber authorized under Iowa law.

114.12(12) *Use of medications.* No prescription medications prescribed for one resident may be administered to or allowed in the possession of another resident.

114.12(13) *Order of authorized prescriber.* No prescription medication may be administered to a resident without the order of an authorized prescriber.

114.12(14) *Patient reaction.* Any unusual patient reaction to a drug shall be reported to the attending physician or prescriber immediately.

114.12(15) *Dilution or reconstitution of drugs.* Dilution or reconstitution of drugs and their labeling shall be done only by a licensed pharmacist.

114.12(16) *Administration of drugs.* Medications shall be administered only in accordance with the instructions of the attending physician or authorized prescriber. Medications shall be administered only by staff who have completed a medication management course. The type and amount of the medication, the time and date, and the staff member administering the medication shall be documented in the child's record.

114.12(17) *Self-administration of drugs.* There shall be written policy and procedures relative to self-administration of prescription medications by residents and only when:

a. Medications are prescribed by a physician or other authorized prescriber.

b. The physician or authorized prescriber provides written approval that the patient is capable of participating and can self-administer the drug.

c. What is taken and when is documented in the record of the child.

114.12(18) *Obtaining nonprescription medications.* Facilities shall maintain a supply of standard nonprescription medications for use for children residing at the facility. Examples of standard nonprescription medications include cough drops and cough syrups, aspirin substitutes and other pain control medication, poison antidote, and diarrhea control medication.

a. All nonprescription medications kept on the premises for the use of residents shall be preapproved annually by a licensed pharmacist or an authorized prescriber.

b. Facilities shall maintain a list of all preapproved nonprescription medications. The list shall indicate standard uses, standard dosages, contraindications, side effects, and common drug interaction warnings. The facility administrator or the administrator's designee shall be responsible for determining the scope of the list and brands and types of medications included.

c. Only nonprescription medications on the preapproved list shall be available for use. However, the facility administrator or the administrator's designee, in consultation with an authorized prescriber or

licensed pharmacist, may approve use of a nonprescription medication that is not on the preapproved list for a specific child.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.13(237) Children's rights.

114.13(1) *Policies in writing.* All policies and procedures covered in this rule shall be in writing and provided to the child and parents or guardian upon the child's admission to the facility. The rationale and circumstances of any deviation from these policies shall be discussed with the child's parents or guardian and the referring worker, documented, and placed in the child's case record.

114.13(2) *Confidentiality.* Information regarding children and their families shall be kept confidential and released only with proper written authority.

114.13(3) *Communication.*

a. Visitation shall be allowed with members of the child's immediate family unless otherwise regulated by the court.

b. Visits shall be allowed with other significant persons.

c. Consideration shall be given to privacy for family visits.

d. The child shall be permitted to communicate with legal counsel and the referring worker.

e. The child shall be allowed to conduct private telephone conversations with family members. Incoming calls may be screened by staff to verify the identity of the caller before approval is given.

f. The child shall be allowed to send and receive mail unopened unless contraindicated. Contraindications, except those listed below, should be documented in the child's file. The facility may require the child to open incoming mail in the presence of a staff member when it is suspected to contain contraband articles, or when there is money that should be receipted and deposited.

g. When limitations on visitation, calls or other communications are indicated, they shall be determined with the participation or knowledge of the child, family or guardian, and the referring worker. All restrictions shall have specific bases which shall be made explicit to the child and family and documented in the child's case record.

114.13(4) *Privacy.* Reasonable provisions shall be made for the privacy of residents.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.14(237) Personal possessions.

114.14(1) *Belongings.* A facility shall allow a child in care to bring personal belongings and to acquire belongings in accordance with the child's service plan. However, the facility shall, as necessary, limit or supervise the use of these items while the child is in care.

114.14(2) *Clothing.* A facility shall ensure that each child in care has adequate, clean, well-fitting, attractive, and seasonable clothing as required for health, comfort, and physical well-being. The clothes should be appropriate to age, sex and individual needs.

[**ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.15(237) Religion—culture.

114.15(1) *Facility orientation.* A facility shall have a written description of its religious orientation, particular religious practices that are observed, and any religious restrictions. This description shall be provided to the child, the parent(s) or guardian, and the placing agency at the time of admission.

114.15(2) *Child participation.* When a facility accepts a child, the child shall have the opportunity to participate in religious activities and services in accordance with the child's own faith or that of the child's parent(s) or guardian. The facility shall, when necessary and reasonable, arrange transportation for religious activities. Wherever feasible, the child shall be permitted to attend religious activities and services in the community.

[**ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.16(237) Work or vocational experiences.

114.16(1) *Written description.* The facility shall have a written statement of any work and vocational experiences available to children.

114.16(2) *Program component.* Work as part of the program shall be identified in the child's case plan.

114.16(3) *Self-care.* Ordinary self-care and self-sufficiency tasks are not considered work.

114.16(4) *Purpose.* Work shall be in the child's interest, within the child's ability, with payment where appropriate, and never solely in the interest of the facility's goals or needs.

[**ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.17(237) Family involvement. There shall be written policies and procedures for family involvement that shall encourage continued involvement of the family with the child.

[**ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.18(237) Children's money.

114.18(1) *Treatment of funds.* Money earned, received as a gift, or as an allowance by a child in care shall be deemed to be that child's personal property.

114.18(2) *Limitations.* The facility shall have a written policy on limitations on the child's use of funds.

114.18(3) *Records.* The facility shall maintain a separate accounting system for children's money.

[**ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.19(237) Child abuse. Written policies shall prohibit mistreatment, neglect, or abuse of children and specify reporting and enforcement procedures for the facility. Alleged violations shall be reported immediately to the director of the facility and the department of human services centralized abuse hotline. Any employee found to be in violation of Iowa Code chapter 232, subchapter III, part 2, as substantiated by the department of human services' investigation shall be subject to the agency's policies concerning dismissal.

[**ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.20(237) Discipline.

114.20(1) *Generally.* The facility shall have written policies regarding methods used for control and discipline of children which shall be available to all staff and to the child's family. Agency staff shall be in control of and responsible for discipline at all times. Discipline shall not include the withholding of basic necessities such as food, clothing, or sleep. Discipline shall not be used for anyone other than a child whose actions resulted in consequences. Group discipline shall not be used because of actions of an individual child or other children.

114.20(2) *Corporal punishment prohibited.* The facility shall have a policy that clearly prohibits staff or the children from utilizing corporal punishment as a method of disciplining or correcting children. This policy is to be communicated, in writing, to all staff of the facility.

114.20(3) *Physical restraint.* The use of physical restraint shall be employed only to prevent the child from injury to self, to others, or to property. Physical restraint must be conducted with the child in a standing position whenever possible. Each child has the right to be free from restraint and seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

a. No staff person shall use any restraint that obstructs the airway of a child.

b. Prone restraint is prohibited. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint.

c. If a staff person physically restrains a child who uses sign language or an augmentative mode of communication as the child's primary mode of communication, the child shall be permitted to have the child's hands free of restraint for brief periods unless the staff person determines that such freedom appears likely to result in harm to the child, others, or property.

d. The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the child's rights and to ensure safety shall be clearly documented in the child's record by the responsible staff persons no later than the end of the shift in which the restraint was used.

e. Documentation of restraint use shall include, but need not be limited to, the following:

(1) Each use of restraint or control room.

(2) The time the intervention began and ended.

(3) The reason that required the resident to be restrained or put in a control room.

(4) The name of staff involved in the intervention.

114.20(4) *Other restraints and control room.* Only comprehensive residential facilities may use a control room, locked cottages, or mechanical restraints.

114.20(5) *Behavior expectations.* The facility shall make available to the child and the child's parents or guardian written policies regarding the following areas:

a. The general expectation of behavior including the facility's rules and practices.

b. The range of reasonable consequences that may be used to deal with inappropriate behavior.

114.20(6) *Time out.*

a. A resident in time out must never be physically prevented from leaving the time out area.

b. Time out may take place away from the area of activity or from other residents, such as in the resident's room, or in the area of activity of other residents.

c. Staff must monitor the resident while the resident is in time out.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.21(237) Illness, accident, death, or unauthorized absence from the facility.

114.21(1) *Notification of illness.* A facility shall notify the child's parent(s), guardian and responsible agency of any serious illness, incident involving serious bodily injury, circumstances causing removal of the child from the facility, or elopement.

114.21(2) *Notification of death.* In the event of the death of a child, a facility shall notify immediately the physician, the child's parent(s) or guardian, the placing agency, and the appropriate state authority. The agency shall cooperate in arrangements made for examination, autopsy, and burial.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.22(237) Records. In the event of closure of a facility, children's records shall be sent to the department of human services for retention according to the department's records retention policy or the period defined in the department's contract for services, whichever is longer.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.23(237) Unannounced visits.

114.23(1) Frequency.

a. Time. At least one annual unannounced visit shall occur during periods of the day when the child would normally be in the facility and awake.

b. Activities. The visit shall include an assessment of, but not be limited to, the following areas:

(1) Interaction between the staff and child.

(2) Interaction between the children.

(3) Discussion with the child about experiences in the facility.

(4) A check on any previously cited deficiencies.

(5) Overall impression of the facility.

(6) Staff record checks.

c. Recommendation. The licensing staff shall recommend follow-up when needed.

114.23(2) Visits at other times may occur as a result of a self-reported incident or specific complaint.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.24(237) Record check information. Record checks are required for any entity being considered for licensure or employment by a licensee on a facility campus where children reside to determine whether any founded child abuse reports or criminal convictions exist or whether the entity has been placed on a sex offender registry. The facility shall not employ any person who has been convicted of a crime involving the mistreatment or exploitation of a child. The facility shall not employ any person who has a record of a criminal conviction or founded child abuse report unless the department has evaluated the crime or abuse and determined that the crime or abuse does not merit prohibition of licensure, volunteering or employment.

114.24(1) *Procedure.* Each entity being considered for licensure or employment shall be checked for all of the following:

a. Records with the Iowa central abuse registry, using the request for child and dependent adult abuse information form;

b. Records with the Iowa division of criminal investigation, using the department's criminal history record check form;

c. Records with the Iowa sex offender registry;

d. Records with the child abuse registry of any state where the person has lived during the past five years; and

e. Fingerprints provided to the department of public safety for submission through the state criminal history repository to the United States Department of Justice, Federal Bureau of Investigation, for a national criminal history check. Fingerprinting, for the purpose of a national criminal history check, is required for all entities considered for licensure or employment by a licensee on a facility campus where children reside.

114.24(2) *Evaluation of record.* If an entity for which a background check is required has a record of founded child or dependent adult abuse, a criminal conviction, or placement on a sex offender registry, the department shall prohibit licensure or employment unless an evaluation determines that the abuse, criminal conviction, or placement on a sex offender registry does not warrant prohibition.

a. Scope. The evaluation shall consider the nature and seriousness of the founded child or dependent adult abuse or criminal conviction report in relation to:

(1) The position sought or held,

(2) The time elapsed since the abuse or crime was committed,

(3) The circumstances under which the abuse or crime was committed,

(4) The degree of rehabilitation,

(5) The likelihood that the person will commit the abuse or crime again, and

(6) The number of abuses or crimes committed by the person.

b. Evaluation form. The person with the founded child or dependent adult abuse or criminal conviction report shall complete and return the department's record check evaluation form within ten calendar days of the date of receipt to be used to assist in the evaluation.

114.24(3) *Evaluation decision.* The department shall conduct the evaluation and make the decision of whether or not the founded child or dependent adult abuse or criminal conviction warrants prohibition of licensure or employment by a licensee. The department shall issue a notice of decision in writing to the requesting entity. The requesting entity is responsible for providing a copy of the notice to the prospective employee. Record check evaluations are valid for 30 days from the date the notice of decision is issued.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

441—114.25(237) Standards for private juvenile shelter care and detention homes. The standards of 441—Chapter 105 shall be used as the basis for licensing private juvenile shelter care and detention homes. These homes are not required to meet other standards of 441—Chapter 114.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6962C**, IAB 4/5/23, effective 6/1/23]

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CHAPTER 115
LICENSING AND REGULATION OF COMPREHENSIVE RESIDENTIAL FACILITIES FOR CHILDREN

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

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

441—115.1(237) Applicability. This chapter relates specifically to the licensing and regulation of comprehensive residential care facilities. Refer to 441—Chapter 112 for the basic licensing and regulation of all foster care facilities and 441—Chapter 114 for definitions and minimum standards for all group living foster care facilities.

This rule is intended to implement Iowa Code chapter 237.

441—115.2(237) Definitions.

"Comprehensive residential facility" means a facility which provides care and treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual service plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, and mechanical restraints when these controls meet licensing requirements.

"Locked cottage" means an occupied comprehensive residential facility or an occupied unit of a comprehensive residential facility which is physically restrictive because of the continual locking of doors to prevent the children in care from leaving the facility.

"Protective locked environment" means the same as defined in Iowa Code section 237.1(17).

"Secure facility" means any comprehensive residential facility which employs, on a regular basis, locked doors or other building characteristics intended to prevent children in care from leaving the facility without authorization. Secure facilities may only be used for children who have been adjudicated delinquent or placed pursuant to provisions of Iowa Code chapter 229.

This rule is intended to implement Iowa Code chapter 237.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 0109D**, IAB 3/4/26, effective 5/1/26]

441—115.3(237) Information upon admission. In addition to the requirements in 114.9(4)*"b,"* parents or guardians shall be provided with information on conditions for the use of restraints.

This rule is intended to implement Iowa Code section 237.3.

441—115.4(237) Staff.

115.4(1) *Number of staff.*

a. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to eight staff-to-child ratio at all times children are awake and present in the facility and during supervised outings.

b. A staff person shall be in each living unit at all times when children are in residence.

115.4(2) *Staff duties.*

a. A casework supervisor shall provide:

(1) One hour per week per caseworker of in-person case specific supervision.

(2) On-site supervision at least monthly.

(3) Additional contact as needed with each caseworker in other related duties including case intake discussions, staffings of cases, evaluations of the caseworker, teaching, and administrative duties.

b. Casework staff shall:

(1) Provide at least weekly group or individually scheduled in-person conferences with each resident for whom the caseworker is responsible. More frequent in-person contact shall be provided if required in the service plan.

(2) Provide a supportive and therapeutic atmosphere for the child.

(3) Select and employ appropriate treatment approaches to different types of children.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11; **ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6963C**, IAB 4/5/23, effective 6/1/23]

441—115.5(237) Casework services. The facility shall have the internal capacity to provide individual, family and group counseling and shall provide, but not be limited to, casework dealing with crisis intervention, daily living skills, peer relationships, future planning and preparation for discharge.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6963C**, IAB 4/5/23, effective 6/1/23]

441—115.6(237) Restraints.

115.6(1) *Protective locked environment facilities.* Physical restraints and a control room are permitted in protective locked environment facilities.

115.6(2) *Secure facilities.* Secure facilities may use physical restraints, a control room, locked cottages, and mechanical restraints.

115.6(3) *Written policies.* A facility that uses restraints shall have a written policy on their use. This policy shall include:

a. A statement specifically identifying each form of restraint in use at the facility.

b. Criteria for use of each form of restraint.

c. Identification of staff or licensed professionals authorized to approve and use each form of restraint.

d. Requirement for documentation in the child's individual case file.

e. Procedures for application or administration of each form of restraint.

f. Maximum time limit for use of restraints.

115.6(4) *Use of restraint.*

a. A facility shall not use, apply, or administer restraint in any manner which causes physical injury.

b. A facility shall not use restraint as a disciplinary or punitive measure, for staff convenience, as a preventive measure, or as a substitute for programming.

c. A secure facility which uses restraint permitted by licensing standards, other than physical restraint, shall ensure that all direct service staff are adequately trained in the following areas:

(1) The appropriate use and application or administration of each permitted form of restraint.

(2) The facility's policies and procedures related to restraint.

(3) Crisis management techniques.

d. A secure facility shall continually review any use of a restraint on a child, other than physical restraint.

e. A facility shall release the child from restraint immediately when the situation precipitating restraint no longer exists.

This rule is intended to implement Iowa Code section 237.4.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6963C**, IAB 4/5/23, effective 6/1/23; **ARC 0109D**, IAB 3/4/26, effective 5/1/26]

441—115.7(237) Control room.

115.7(1) *Purpose.* The control room shall be used for treatment purposes only. A facility shall be approved by the licensing authority as meeting the requirements of this chapter regarding control rooms before control rooms can be utilized.

115.7(2) *Written policies.* When a comprehensive residential facility uses a control room as part of its treatment program, the facility shall have written policies regarding its use. The policy shall:

a. Specify the types of behavior which may result in control room placement.

b. Delineate the staff members who may authorize its use as well as procedures for notification of supervisory personnel.

c. Require documentation in writing of the types of behaviors leading to control room placement and the conditions that will allow the child to return to the living unit. The child shall be informed of these conditions. Documentation of control room use shall include, but not be limited to, the following:

(1) Each use of the control room.

(2) The time the intervention began and ended.

(3) The reason that required the resident to be put in the control room.

(4) The name(s) of staff involved in the intervention.

d. Limit the utilization of the control room to one of the following two circumstances:

(1) The child's service plan includes and explains how this use of the control room fits into the service plan for the child.

(2) A one-time placement in an emergency without a service plan outlining the rationale for its use. This treatment shall be included in the service plan for a second placement of a child in the control room.

115.7(3) *Physical requirements.* The control room shall be designed to ensure a physically safe environment with:

a. All switches controlling lights and ventilation outside the room.

b. Allowance for observation of the child at all times.

c. Protected recessed ceiling light.

d. No electrical outlets in the room.

e. Proper heating, cooling, and ventilation.

f. Any window secured and protected in a manner to prevent harm to the child.

g. A minimum of 54 square feet in floor space with at least a 7-foot ceiling.

115.7(4) *Use of control room.* The control room shall be used only when a less restrictive alternative to quiet the child or allowing the child to gain control has failed and when it is in the service plan. The following policies shall apply to the use of the control room:

a. No more than one child shall be in a control room at any time.

b. There shall be provisions for visual observation of the child at all times, regardless of the child's position in the room.

c. The control room shall be checked thoroughly for safety and the absence of contraband prior to placing the child in the room.

d. The child shall be thoroughly checked before placement in the control room and all potentially injurious objects removed including shoes, belts, and pocket items. The staff member placing the child in the control room shall document each check.

e. In no case shall all clothing or underwear be removed and the child shall be provided sufficient clothing to meet seasonal needs.

f. A staff member shall always be positioned outside of the control room. Visual and auditory observations of the child's behavior and condition shall be recorded at five-minute intervals, and a complete written report shall be documented in the child's file by the end of the staff person's work shift.

g. The child shall remain in the control room longer than one hour only with consultation and approval from the authorized staff or licensed professional. Documentation in the child's case record shall include the time in the control room, the reasons for the control, and the reasons for the extension of time. Use of the control room for a total of more than 12 hours in any 24-hour period shall occur only after authorization of the psychiatrist or upon court order. In no case shall a child be in a control room for a period longer than 24 hours.

h. The child's parents or guardian and the referring worker shall be aware of the control room as a part of the treatment program.

This rule is intended to implement Iowa Code section 237.4.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20; **ARC 6963C**, IAB 4/5/23, effective 6/1/23; **ARC 0109D**, IAB 3/4/26, effective 5/1/26]

441—115.8(237) Locked cottages.

115.8(1) *Approval.* A facility shall be approved by the licensing authority as meeting the requirements of this chapter regarding locked cottages before locked cottages can be operated.

115.8(2) *Nighttime staff.* Awake nighttime staff is required in each locked cottage.

115.8(3) *Policies.* Licensees utilizing a locked cottage shall have and follow written policies for the locked cottage. The policies shall be provided to the child, the child's parents or guardian and, when the child has an attorney, the child's attorney at the time of admission. The policies shall include:

a. The type of behavior which may result in locked cottage placement.

b. The staff members who may authorize placement in the locked cottage as well as procedures for notification of supervisory personnel.

c. Requirements for documentation in writing of particular behaviors of a particular child that led to the placement.

d. Requirement for documentation of the conditions that will allow the child to return to an unlocked cottage. These conditions shall be shared with the child.

e. Requirement for documentation of the use of the locked cottage as a part of the treatment plan for a specific child.

f. Specific policies as to the length of stay in the locked cottage.

g. Requirements for notification of the child's parents or guardian, the court, and the referring agency of a child's placement in the locked cottage.

h. Requirement for written documentation of placements in the locked cottage in the child's case record.

This rule is intended to implement Iowa Code section 237.4.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—115.9(237) Mechanical restraint. When a facility uses mechanical restraints as a part of its treatment program, the facility shall have and follow written policies regarding their use. These policies shall be approved by the licensor prior to their use. The policies shall be available to clients, parents or guardians, and referral sources at the time of admission. Policies shall also be available to staff.

115.9(1) *Restrictions on mechanical restraints.*

a. Mechanical restraints shall not inflict physical injury.

b. Each use of mechanical restraint shall be authorized by the administrator or case supervisor.

c. Each authorization of mechanical restraint shall not exceed one hour in duration.

d. No child shall be kept in mechanical restraint for more than two hours in a 12-hour period.

e. Any time that a child is placed in mechanical restraint a staff person shall be assigned to monitor the placement with no duties other than to ensure that the child's physical needs are properly met. The staff person shall remain in continuous auditory and visual contact with the child.

f. Each child shall be released from mechanical restraint as soon as the restraints are no longer needed.

115.9(2) *Continued use of mechanical restraints.* When a child requires mechanical restraint on more than four occasions during any 30-day period, the facility shall hold an immediate emergency meeting to discuss the appropriateness of the child's continued placement at the facility.

115.9(3) *In transporting children.* Notwithstanding paragraph 115.9(1)*"d,"* mechanical restraint of a child in case of a secure facility while that child is being transported to a point outside the facility is permitted when there is a serious risk of the child exiting the vehicle while the vehicle is in motion. The facility shall place a written report on each use in the child's case record. This report shall document the necessity for the use of restraint. Seat belts are not considered mechanical restraints. Agency policies should encourage the use of seat belts while transporting children and comply with Iowa law.

This rule is intended to implement Iowa Code section 237.4.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—115.10(237) Restraint and control room use debriefing.

115.10(1) *Initial discussion.* Within a short time after the use of the restraint or control room, staff involved in an intervention and the resident must have a face-to-face discussion except when the presence of a particular staff person may jeopardize the well-being of the resident.

a. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s).

b. The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of the restraint or control room and strategies to be used by the staff, the resident, or others that could prevent the future use of the restraint or control room.

115.10(2) *Staff discussion.* Within 24 hours after the use of the restraint or control room, all staff involved in the intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of the intervention including, but not limited to, the following:

a. The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention;

b. Alternative techniques that might have prevented the use of the restraint or control room;

c. The procedures, if any, that staff are to implement to prevent any recurrence of the use of the restraint or control room; and

d. The outcome of the intervention, including any injuries that may have resulted from the use of the restraint or control room.

115.10(3) *Documentation.* Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, the names of staff who were excused from the debriefing, and any reasons that are applicable.

This rule is intended to implement Iowa Code section 273C.3.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

441—115.11(237) Chemical restraint. Chemical restraint shall not be utilized in a comprehensive residential facility and each comprehensive residential facility shall have written policies that clearly prohibit the use of chemical restraint.

This rule is intended to implement Iowa Code section 273C.3.

[**ARC 4793C**, IAB 12/4/19, effective 1/8/20]

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CHAPTER 116
LICENSING AND REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN WITH AN INTELLECTUAL DISABILITY OR BRAIN INJURY

[Prior to 7/1/83, Social Services[770] Ch 116]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/32

441—116.1(237) Definitions.

"Caseworker" means the same as defined in 441—Chapter 114.

"Casework supervisor" means the same as defined in 441—Chapter 114.

"Child care worker" means the same as defined in rule 441—114.2(237).

"Community residential facility for children with an intellectual disability or brain injury" means the same as a community residential facility as defined in rule 441—114.2(237).

"Comprehensive residential facility for children with an intellectual disability or brain injury" means a comprehensive residential facility as defined in rule 441—115.2(237).

"Direct-service provider" means any employee of an agency whose primary responsibility is the care and programming of the children through direct interactions.

"Indirect-service provider" means an employee of an agency who supervises, coordinates and administers employees and program components.

[**ARC 0768D**, IAB 11/25/26, effective 1/1/27]

441—116.2(237) Qualifications of staff.

116.2(1) *Direct-service providers.* Direct-service providers shall be paraprofessionals or professionals meeting all of the following criteria:

a. Paraprofessionals shall:

(1) Be at least 18 years of age.

(2) Have graduated from high school or earned a high school equivalency degree.

(3) Have completed the prescribed agency training program.

(4) Be appropriate to the specific job description of the employing agency.

b. Professionals in the direct-service provider category shall:

(1) Be at least 18 years of age.

(2) Have a bachelor of arts degree in a related field; or an associate of arts degree in a related field and two years' experience specific to the job responsibilities; or two years of higher education in a related field and two years' experience specific to job responsibilities; or four years' experience in programming specific to job responsibilities.

(3) Have completed the prescribed agency training program.

(4) Be appropriate to the specific job description of the employing agency.

116.2(2) *Indirect-service providers.* Indirect-service providers shall meet one of the following education and experience criteria:

a. Have a master of social work degree or a master of arts degree in a related field and one year of experience specific to job responsibilities.

b. Have a bachelor of arts degree in a related field and two years' experience specific to job responsibilities.

c. Have an associate of arts degree in a related field and four years' experience specific to job responsibilities.

d. Have five years' specific treatment program experience relating to the job responsibilities.

[**ARC 0768D**, IAB 11/25/26, effective 1/1/27]

441—116.3(237) Staff-to-client ratio. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one-to-four staff-to-client ratio during prime programming time.

[**ARC 0768D**, IAB 11/25/26, effective 1/1/27]

441—116.4(237) Program components. In addition to the requirements of 441—subrule 114.8(3), the facility shall have and follow a written procedure that defines who is responsible for overseeing personal hygiene of children and maintaining general orderliness of the facility.
[**ARC 0768D**, IAB 11/25/26, effective 1/1/27]

441—116.5(237) Restraint. In addition to the provisions of 441—Chapters 114 and 115, a restraint may be used as stated in the child's individual service plan as approved by the parent or guardian, caseworker, and facility as long as that facility meets the standards for utilizing that particular type of restraint.
[**ARC 0768D**, IAB 11/25/26, effective 1/1/27]

These rules are intended to implement Iowa Code chapter 237.

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CHAPTER 117
FOSTER PARENT TRAINING

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

Preamble

These rules describe required foster parent orientation, preservice training and in-service training. Their purpose is to ensure that the training and orientation are effective in preparing foster parents for their role. These rules also describe the standards for training and orientation and the procedure to be approved as a training provider.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.1(237) Required preservice training. Foster parent preservice training shall be offered by the department or by a licensed child-placing agency through a training program that has been approved by the department pursuant to rule 441—117.5(237).

117.1(1) *Preservice training requirement.* Each individual foster parent applicant shall complete the entire 30-hour preservice training as approved by the foster family program manager.

a. Applicants shall complete the 30-hour preservice training before receiving a license for the first time.

b. Applicants shall retake the 30-hour preservice training if they do not complete the curriculum within 24 months after initially commencing it.

c. The department may waive the preservice training requirement in whole or in part when the department finds that:

(1) The applicant has completed relevant training or has a combination of relevant training and experience that is an acceptable equivalent to all or a portion of the required preservice training; or

(2) There is good cause for the waiver based upon the circumstances of the child and the applicant.

117.1(2) *Preservice training program approval requirements.*

a. Content. The program shall be designed to assist prospective foster parents in developing the understanding and abilities that are essential to promote children's safety, permanence, and well-being. The program shall address the following topics:

(1) Children in foster care, their needs and rights.
(2) Families of children in foster care, their rights and responsibilities.
(3) Caseworkers and their role.
(4) Foster parents, their motivation and role.
(5) Self-assessment of foster parent's strengths.
(6) The team effort of foster parents and caseworkers.
(7) The impact of foster care placement on the child, the child's family and the foster family.
(8) The purpose and importance of the child's contact with the child's family.
(9) Training in communication and behavior management.
(10) Permanency planning.
(11) The reasons for placement termination and feelings involved.

b. Length. The entire preservice training program shall total at least 30 hours of contact between leaders and participants. The department's recruitment and retention contractor shall devise a procedure for applicants to make up any portions of the preservice training that are missed.

c. Instructors. The program shall be team taught by at least one foster or adoptive parent and one casework staff person. All instructors shall be certified leaders or as approved by the adult, children and family services division administrator or designee.

d. Group method. The program shall be provided in groups that consist of three or more persons. The training shall be offered to a foster family individually only when the foster family is unable to attend group training for reasons such as serious medical conditions, as approved by the social work administrator or designee.

e. Training certificate. A certificate of completion shall be provided to each foster parent who completes the training.

f. Training evaluation. A means for participants in the training to evaluate the instructors and the content shall be provided.

g. Training records. A record of the applicants who begin and complete the training and of the training program evaluations shall be submitted to the recruitment and retention contractor at the end of each 30-hour preservice training session.

117.1(3) *Universal precautions.* Before licensure, each individual foster parent shall complete one hour of training related to the use and practice of universal precautions. Training shall be completed through the approved individual self-study course, "Universal Precautions in Foster and Adoptive Resource Family Homes."

117.1(4) *Additional preservice training.* Before licensure, each foster parent shall complete training in an agency-approved medication management course, cardiopulmonary resuscitation (CPR), first aid, the reasonable and prudent parent standard, and the mandatory reporter training on child abuse identification. Training shall also be completed that teaches foster parents how to support a child's overall well-being and emotional needs.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 1808C**, IAB 1/7/15, effective 3/1/15; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6715C**, IAB 11/30/22, effective 2/1/23]

441—117.2(237) Required orientation. All foster parent applicants shall attend orientation before attending the 30-hour preservice training and before a foster child is placed in their home. Orientation shall not count toward the required 30 hours of preservice training.

117.2(1) *Method of provision.* The recruitment and retention contractor may provide orientation:

a. In an individual meeting with one set of foster parent applicants; or

b. In a group setting.

117.2(2) *Provider.* Orientation shall be provided by the recruitment and retention contractor completing the family's licensing study.

117.2(3) *Content.* Orientation shall be designed to provide the foster parent applicant with information on the policies and procedures of the foster care and adoption programs and shall include the following:

a. Process and procedures for placement and termination of placement.

b. Medical assistance program information.

c. Foster family reimbursement information and adoption subsidy information if applicable.

d. Child abuse law and child abuse assessment procedures.

e. Confidentiality.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 1808C**, IAB 1/7/15, effective 3/1/15; **ARC 5361C**, IAB 12/30/20, effective 3/1/21]

441—117.3(237) Application materials for in-service training. Applications for approval of an in-service training program shall be submitted on Form 470-2541 and must be approved before the delivery of the training. Applications submitted after a training is completed shall not be approved.

117.3(1) Except for cardiopulmonary resuscitation and first-aid training, foster parent in-service training shall meet the requirements in rule 441—117.7(237).

117.3(2) Applications shall be submitted with the following materials:

a. A detailed training program description relative to a foster parent, including objectives, program agenda, content, participant materials, and time frames.

b. Names of program instructors and their qualifications to provide the training.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 6715C**, IAB 11/30/22, effective 2/1/23]

441—117.4(237) Application process for in-service training.

117.4(1) *Group training.* Applications to provide group foster parent training shall be submitted to the department office for the service area in which the training will be conducted.

117.4(2) *Individual training.* Applications for approval for individual training, college credit, written materials, DVDs or videotapes shall be submitted to the department office for the service area in which the foster family resides.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.5(237) Application decisions. The department shall notify the applicant of its decision regarding the application for approval of in-service training within 30 days of receipt of the training materials described in rule 441—117.3(237). This notification shall include the reason for not giving approval if approval is denied.

117.5(1) *Approval.* Foster parent training programs which meet the criteria in rule 441—117.1(237) or in rule 441—117.7(237) and which are submitted pursuant to rules 441—117.3(237) and 441—117.4(237) shall be approved by the department. In-service training completed before the program has received department approval shall not count toward the required six credit hours of in-service training. In-service training approvals are valid for one year.

117.5(2) Reserved.

117.5(3) *Denial.* Preservice training programs which do not meet the requirements in rules 441—117.1(237), 441—117.3(237), and 441—117.4(237) and in-service training programs which do not meet the criteria in rules 441—117.3(237), 441—117.4(237) and 441—117.7(237) shall be denied approval. The applicant may submit a revised program for approval at a later date.

117.5(4) *Revocation.* Approval shall be revoked when any of the following exist and corrective action is not taken to correct the deficiencies within 45 days.

a. The training provider fails to provide the training as described in the approved application materials.

b. Over 25 percent of the participant evaluations of the training program rate the training program as not helpful.

If approval is revoked, the training provider may submit a revised program at a later date.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 6715C**, IAB 11/30/22, effective 2/1/23]

441—117.6(237) Application conference available. If an applicant or provider of training objects in writing within seven days after the notification of the department's decision to deny approval, the area social work administrator shall review the decision to determine if the original decision shall stand. The decision of the area social work administrator is final and is not subject to appeal.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.7(237) Required in-service training. At least six hours of in-service training are required to assist foster parents in confidently and effectively addressing the needs of children placed in foster care. Form 470-3341 shall be used to address in-service training needs. The training plan shall be developed with the department or retention and recruitment contractor and the foster parent annually.

117.7(1) *Providers of in-service training.* Foster parent in-service training may be provided by the department, a licensed child-placing or child-caring agency, or an agency, institution, or association with expertise in the training content. Agencies, institutions, or associations wishing to have a foster parent in-service training program or workshop approved shall submit application materials pursuant to rules 441—117.3(237) and 441—117.4(237).

117.7(2) *In-service training program approval requirements.*

a. Content. The program shall relate to the foster parent's role in providing foster care and the skills needed by a foster parent. Training shall be specific to developing each foster parent's skills for addressing the needs of foster children.

b. Method. The training shall be provided through one or more of the following methods:

(1) Face-to-face or interactive virtual training to a group.

(2) Face-to-face or interactive virtual training to an individual foster family.

(3) Written materials.

(4) DVDs or videotapes.

(5) Internet training classes offered through the Iowa Foster and Adoptive Parents Association (IFAPA).

(6) Internet training classes offered through www.fosterparents.com, except for cardiopulmonary resuscitation and first-aid trainings, which are not approved.

c. Credit hours. Credit hours for approved training shall be as follows:

(1) Group training shall receive one credit hour for each face-to-face or interactive virtual contact hour.

(2) Written materials shall receive one credit hour for each 100 pages.

(3) DVDs or videotapes shall receive one credit hour for each two program hours.

(4) College courses shall receive one credit hour for each college credit hour.

(5) Internet training classes shall receive one credit hour for each program hour. A maximum of three hours of training credit per year may be earned through the website www.fosterparents.com.

d. Approved training. The following training programs shall be considered as meeting the in-service training requirements:

(1) Workshops offered at the Iowa Association of Foster and Adoptive Parents' annual state conference.

(2) Workshops offered at the National Foster Parent Association's annual conference.

117.7(3) *Foster parent training requirements.* Each individual foster parent shall complete six credit hours of department-approved in-service training annually when the foster parent has an approved one-year license or an approved two-year license.

a. Renewal license. For a one-year license renewal, each foster parent shall complete six hours of annual in-service training within the 12-month period beginning on the effective date of the foster parent's renewal license. For a two-year license renewal, each foster parent shall complete six hours of in-service training within the 12 months of the first license year beginning on the effective date of the two-year license renewal. For the second year of a two-year license renewal, each foster parent shall complete six hours of in-service training within the 12 months of the second year of the two-year license renewal.

b. Content. The choice of in-service training shall be based upon an assessment of the foster parent's training needs made by the foster parent and the recruitment and retention contractor in collaboration with the department licensing worker.

(1) Each foster parent must complete the specific training required in rule 441—117.8(237).

(2) At least three credit hours of the annual six hours of in-service training shall be group training.

(3) Except for the mandatory reporter training on child abuse identification class, training credit will not be allowed for any in-service training class that is repeated unless the class has been updated with new information.

c. Documentation. Each individual foster parent shall submit Form 470-2540 to the recruitment and retention contractor within 30 days after completion of each in-service training.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 6715C**, IAB 11/30/22, effective 2/1/23]

441—117.8(237) Specific in-service training required.

117.8(1) *Cardiopulmonary resuscitation (CPR).* All foster parents shall maintain their CPR certification and a certificate or card indicating the date of training and expiration. The training shall be provided by:

a. A nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid), or

b. An equivalent certified trainer and curriculum approved by the department.

117.8(2) *First aid.* All foster parents shall be certified in first aid at least every two years and shall maintain their first-aid certification and a certificate or card indicating the date of training and expiration.

117.8(3) *Child abuse reporting.* Each foster parent shall complete an approved mandatory child abuse reporter training every three years after the foster parent's initial preservice mandatory child abuse reporter training relating to the identification of child abuse and the requirements and procedures for the reporting of child abuse pursuant to Iowa Code section 232.68.

a. Training provider. The foster parent shall be responsible for completing the required two-hour mandatory reporter training on child abuse identification and reporting in accordance with Iowa Code section 232.69. Foster parents are eligible to take the one-hour recertification mandatory reporter training on child abuse identification and reporting within the six months prior to the expiration of their previous certification if they have already completed the two-hour training at least once.

b. Documentation. The foster parent shall secure documentation of the training content, amount, and provider and shall forward the documentation to the recruitment and retention contractor, who will provide the documentation to the department for inclusion in the foster parent's licensing file.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 5361C**, IAB 12/30/20, effective 3/1/21; **ARC 6715C**, IAB 11/30/22, effective 2/1/23]

441—117.9(237) Foster parent training expenses. No expense stipend is provided for orientation or preservice training.

117.9(1) *Training stipend.* Each family that is issued an initial or renewal foster family home license shall receive a $100 stipend to be used for the family's annual in-service training. The department's recruitment and retention contractor shall issue one stipend per license on or after the date that the license is issued. When a family with a two-year foster family home license has completed the first training cycle of six hours of in-service training, the contractor shall issue the next training stipend no earlier than the start of the second year of licensure contingent upon the foster family's completion of the in-service training hours in the first cycle. Foster families who elect not to receive the $100 stipend shall notify the department and the contractor.

117.9(2) *Trainer fees.* Foster parents and social workers who serve as trainers for approved preservice training programs shall each be paid a contract fee per class hour appropriate to community standards based upon the education and experience of each trainer. These rates shall be negotiated between the recruitment and retention contractor and the trainer.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12; **ARC 6715C**, IAB 11/30/22, effective 2/1/23]

These rules are intended to implement Iowa Code section 237.5A.

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CHAPTER 118
CHILD CARE QUALITY RATING SYSTEM

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

DIVISION I
QUALITY RATING SYSTEM (QRS)

Preamble

Division I of this chapter establishes rules for the child care quality rating system, which is designed for child care programs that primarily serve children between birth and the age of 12. Participation in the quality rating system is voluntary. Division I includes application procedures and standards for the quality rating. Rules 441—118.1(237A) through 441—118.8(237A) are in effect until Division I sunsets, when all providers approved for this program are no longer eligible under Division I. As of June 1, 2022, child care programs applying for a new rating will apply to the Iowa quality for kids (IQ4K) quality rating improvement system outlined in Division II.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11; **ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.1(237A) Definitions.

"Aim4Excellence credential" means the national director credential for early childhood administrators that is administered by the McCormick Center for Early Childhood Leadership.

"Apprenticeship certificate" means a nationally recognized Child Care Development Specialist Registered Apprenticeship Certificate awarded by the U.S. Department of Labor. The certificate requires two years of full-time employment with on-the-job training and 288 hours (at least 19 credits) of approved, related college education or training.

"Child care facility" means a licensed child care center, a preschool, or a registered child development home.

"Child care nurse consultant" means a registered nurse licensed in the state of Iowa who has completed training using a nationally approved curriculum for health and safety in child care and early education. The child care nurse consultant provides on-site consultation, technical assistance, and training to child care and early education providers regarding health and safety. The child care nurse consultant is employed by or has a written agreement with the local Title V maternal and child health agency or contracts for service delivery directly through the state-level Title V maternal and child health program administered by the Iowa department of public health, bureau of family health.

"Child development associate credential (CDA)" means a credential awarded by the Council for Professional Recognition to individuals working in child care settings who demonstrate proficiency in specific competency standards. The credential requires 120 hours of approved training over the past five years.

"ChildNet certification" means verified completion of the 25-hour ChildNet training series in areas specifically designed for child development home providers and completion of the certification process.

"Department" means the department of human services.

"Eligible applicants" means programs meeting the definition of "child care facility" or programs operating under the authority of an accredited school district or nonpublic school.

"Environment rating scale" means a child care program assessment instrument (scale) developed through the auspices of the Frank Porter Graham Child Development Center of the University of North Carolina at Chapel Hill. The scale is the measurement tool used by an assessor during an on-site observation of a child care classroom to evaluate and provide a score to a child care program. Scales must be administered by entities approved by the department of human services or the department's designee. Four scales are available, based on the type of program being assessed:

1. Family child care environment rating scale for programs conducted in a provider's own home for children from infancy through school age.

2. Infant/toddler environment rating scale for group programs for children from birth to 2½ years of age.

3. Early childhood environment rating scale for group programs for children of preschool through kindergarten age, 2½ to 5 years.

4. School-age care environment rating scale for group programs for children of school age, 5 to 12 years.

"Head Start program performance standards" means the standards that define the services that Head Start programs are required to provide to the children and families they serve. The standards constitute the expectations and requirements that Head Start grantees must meet.

"Iowa quality preschool program standards" means standards developed by the Iowa department of education, based on the ten standards of the National Association for the Education of Young Children accreditation.

"National administrator credential (NAC)" means the 40-hour comprehensive training for child care and education administrators and successful completion of the certification process.

"Staff in the classroom" means staff responsible for care of children in the classroom.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.2(237A) Application for quality rating. Eligible applicants shall apply for a quality rating by submitting the specified application form and any required supporting documentation to the department. Applications for a Level 1 rating will not be accepted from programs that have previously been rated at Level 1.

118.2(1) *Transition period.* For the period February 1, 2011, through July 31, 2011, eligible applicants may apply for a quality rating either under this subrule or under subrule 118.2(2).

a. A child care center or preschool applying under this subrule shall complete Form 470-4229, Application for Quality Rating—Center/Preschool. The quality rating will be based on the standards in rule 441—118.3(237A).

b. A child development home applying under this subrule shall complete Form 470-4302, Application for Quality Rating—Child Development Home. The quality rating will be based on the standards in rule 441—118.4(237A).

118.2(2) *Ongoing standards.* Effective June 1, 2022, for new applications, child care programs applying for a new rating will apply to the Iowa quality for kids (IQ4K) quality rating system outlined in Division II.

a. A child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school applying under this subrule shall complete Form 470-4902, Quality Rating System Application for Licensed Centers, Preschools, and School-Based Programs. The quality rating will be based on the standards in rule 441—118.5(237A).

b. A child development home applying under this subrule shall complete Form 470-4901, Quality Rating System Application for Child Development Homes. The quality rating will be based on the standards in rule 441—118.6(237A).

118.2(3) *Change in location of facility.* If the location of a rated program changes, the program must notify the department and complete a new application form as specified in subrule 118.2(1) or 118.2(2). The department shall make a new determination of the appropriate rating.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11; **ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.3(237A) Rating standards for child care centers and preschools (sunsetting on July 31, 2011). For applications submitted under subrule 118.2(1), to participate in the quality rating system, a child care center or preschool shall certify that its facility meets the applicable criteria as defined in subrule 118.3(1).

118.3(1) *Criteria.* Criteria for each rating level are defined as follows.

a. Level 1. To be rated at Level 1, a facility must either:

(1) Have a full or provisional license from the department of human services with no action pending to revoke or deny the license; or

(2) Operate under the authority of an accredited school district or nonpublic school.

b. Level 2. To be rated at Level 2, a facility must meet the following criteria:

(1) The facility must have a full license from the department of human services with no action pending to revoke or deny the license, or operate under the authority of an accredited school district or nonpublic school.

(2) The facility must complete the Iowa department of public health's Form HCCI-BPA2006, Child Care Business—Partnership Agreement.

(3) The facility must complete the Iowa department of public health's provider health and safety questionnaire, Form HCCI-CDOS2006, Child Care Center Director/Owner Survey.

(4) If eligible, the facility must participate in the child and adult care food program (CACFP), unless children are in attendance less than four hours per day and the program does not serve meals.

(5) The facility must have on duty in each room at all times at least one staff member who has completed training in mandatory reporting of child abuse, universal precautions and infectious disease control, cardiopulmonary resuscitation, and first aid as specified in 441—subrule 109.7(1) and subparagraphs 109.7(2)*"a"*(1) and (2).

(6) The facility must provide basic orientation for all staff before they begin work.

(7) All staff, including the facility's director, must complete Form 470-4234, Child Care Center Staff Self-Assessment, no more than 12 months before application for quality rating. The director must also complete Form 470-4233, Child Care Center Self-Assessment.

c. Level 3. To be rated at Level 3, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 10 points from the categories listed in subrules 118.3(2) through 118.3(6).

(2) The facility must earn at least one point from each category.

d. Level 4. To be rated at Level 4, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 18 points from the categories listed in subrules 118.3(2) through 118.3(6).

(2) The facility must earn at least one point from each category.

e. Level 5. To be rated at Level 5, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 26 points from the categories listed in subrules 118.13(2) through 118.13(6).

(2) The facility must earn at least one point from each category.

118.3(2) *Professional development.* A child care center or preschool may earn a maximum of 12 points in the professional development category. Points are awarded as follows:

a. Credential. Two points are awarded if the facility director:

(1) Has a current national administrator credential; or

(2) Is a school principal licensed by the Iowa board of educational examiners.

b. Related degree. One point is awarded if at least one staff member at the facility has at least a bachelor's degree in education specific to the age group for whom the person provides care.

c. Education and experience. A facility may earn a maximum of nine points for staff education and experience. Programs may select up to two of the following options:

(1) Five points are awarded if at least 50 percent of staff in each classroom have a minimum of a bachelor's degree in education specific to the age group for whom they provide care.

(2) Four points are awarded if at least 50 percent of staff in each classroom have a minimum of an associate's degree in education specific to the age group for whom they provide care.

(3) Three points are awarded if at least 50 percent of staff in each classroom have a minimum of a child development associate credential or apprenticeship certificate.

(4) Two points are awarded if at least 50 percent of staff in each classroom have a minimum of either six college credit hours in education specific to the age group for whom they provide care or have a paraeducator certificate from the Iowa board of educational examiners.

(5) Two points are awarded if at least 50 percent of staff in each classroom have received a minimum of 30 hours of training beyond regulatory requirements in the last 12 months and have at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school.

(6) One point is awarded if at least 50 percent of staff in each classroom have received a minimum of 15 hours of training beyond regulatory requirements in the last 12 months.

118.3(3) *Health and safety.* A child care center or preschool may earn a maximum of eight points in the health and safety category. Points are awarded as follows:

a. Injury prevention. A facility may earn a maximum of three points for injury prevention. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

b. Child record review. A facility may earn a maximum of two points for child record review. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

c. Health and safety assessment. A facility may earn a maximum of three points for health and safety assessment. Points are awarded as follows:

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.3(4) *Environment.* A child care center or preschool may earn a maximum of 11 points in the environment category. Points are awarded as follows:

a. Environment rating scale training and self-assessment.

(1) One point is awarded if the facility director or assistant director completes approved training on using the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale to evaluate and improve the facility before outside evaluation.

(2) One point is awarded if, after completing training on how to use the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale, the facility director or assistant director completes a self-assessment of at least one-third of the facility's classrooms, including at least one classroom in each age group served by the facility using the appropriate environment rating scale.

(3) One point is awarded if, after completing training on how to use the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale, the facility director or assistant director completes Form 470-4288, Child Care Center Improvement Plan, based on the environment rating scale self-assessment. Form 470-4288 must be completed for each room for which a self-assessment was completed.

b. Environment rating scale. A facility may earn a maximum of three points on the environment rating scale. The facility director or assistant director must complete training on the use of one of the environment rating scales before requesting assessment. An assessor approved by the department of human services or the department's designee must perform the environment rating assessment. At least one-third of the facility's classrooms must be assessed, including at least one classroom in each age group served by the facility. Points are awarded as follows:

(1) One point is awarded if the facility receives an average score of 3 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

(2) Two points are awarded if the facility receives an average score of 4 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

(3) Three points are awarded if the facility receives an average score of 5 on a scale of 7 (with no subscale scores lower than 2) on the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale.

c. Iowa quality preschool program standards. A facility may earn a maximum of two points on the Iowa quality preschool program standards. Points are awarded as follows:

(1) One point is awarded if the facility completes training on Iowa quality preschool program standards.

(2) One point is awarded if the facility completes the Iowa quality preschool program standards self-assessment and develops a quality improvement plan.

d. Accreditation. A facility may earn a maximum of three points for accreditation. Points are awarded as follows:

(1) One point is awarded if the facility meets accreditation standards for group or class size from an accrediting body identified in subparagraph (2) that is appropriate to the child care setting.

(2) Three points are awarded if the facility is accredited by the National Association for the Education of Young Children, the National Afterschool Association, or another accrediting body approved by the department of human services or if a Head Start program demonstrates compliance with Head Start program performance standards.

118.3(5) *Family and community partnerships.* A child care center or preschool may earn a maximum of two points in the family and community partnerships category. Points are awarded as follows:

a. One point is awarded if the facility or the facility director is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the facility provides orientation for new parents and holds annual conferences with parents.

118.3(6) *Leadership and administration.* A child care center or preschool may earn a maximum of four points in the leadership and administration category. Points are awarded as follows:

a. One point is awarded if the facility completes yearly written evaluations for all staff.

b. One point is awarded if the facility develops and updates Form 470-4235, Child Care Center Improvement Plan, annually.

c. One point is awarded if all staff complete Form 470-4236, Professional Development Plan.

d. One point is awarded if all staff who have direct contact with children have a full, facility-based orientation within four months of beginning employment with the facility.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.4(237A) Rating criteria for child development homes (sunsetting on July 31, 2011). For applications submitted under subrule 118.2(1), to participate in the quality rating system, a child development home provider shall certify that the home meets the applicable criteria as defined in subrule 118.4(1).

118.4(1) *Criteria for each rating level.*

a. To be rated at Level 1, the home must be a registered child development home.

b. To be rated at Level 2, the home must meet the following criteria in addition to meeting the criterion for Level 1:

(1) The provider completes and maintains ChildNet certification.

(2) The provider participates in the child and adult care food program (CACFP).

(3) The provider completes the Iowa department of public health's Form HCCI-BPA2006, Child Care Business—Partnership Agreement.

(4) The provider completes the Iowa department of public health's provider health and safety questionnaire, Form HCCI-HDOS2006, Home Child Care Center Director/Owner Survey.

(5) The provider completes Form 470-4231, Child Development Home Professional Development Self-Assessment.

(6) The provider completes Form 470-4236, Professional Development Plan.

c. To be rated at Level 3, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of seven points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

d. To be rated at Level 4, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 12 points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

e. To be rated at Level 5, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 16 points from the categories listed in subrules 118.4(2) through 118.4(5).

(2) The home must earn at least one point from each category.

118.4(2) *Professional development.* A child development home may earn a maximum of six points in the professional development category. Points are awarded as follows:

a. Experience and training. A home may earn a maximum of two points for experience and training. Points are awarded as follows:

(1) One point is awarded if the provider has at least two years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 10 hours of additional training per year beyond regulatory requirements.

(2) Two points are awarded if the provider has at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 20 hours of additional training per year beyond regulatory requirements.

b. Education. A home may earn a maximum of four points for education. Points are awarded as follows:

(1) Two points are awarded if the provider has completed an apprenticeship certificate, child development associate credential, or at least nine college credit hours in education specific to the age group for whom care is provided.

(2) Three points are awarded if the provider has completed an associate's degree in education specific to the age group for whom care is provided.

(3) Four points are awarded if the provider has completed a bachelor's degree or higher in education specific to the age group for whom care is provided.

118.4(3) *Health and safety.* A child development home may earn a maximum of eight points in the health and safety category. Points are awarded as follows:

a. Injury prevention. A home may earn a maximum of three points for injury prevention. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the provider has completed all corrections.

b. Child record review. A home may earn a maximum of two points for child record review. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has worked with the child care nurse consultant to refer families to health care providers.

c. Health and safety assessment. A home may earn a maximum of three points in the health and safety assessment category. Points are awarded as follows:

(1) One point is awarded if the provider completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the provider has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the provider has completed all corrections.

118.4(4) *Environment.* A child development home may earn a maximum of eight points in the environment category. Points are awarded as follows:

a. Environment rating scale training and self-assessment. A home may earn a maximum of three points for environment rating scale training and self-assessment. Points are awarded as follows:

(1) One point is awarded if the provider completes approved training on how to use the family day care rating scale to assess the child development home environment.

(2) One point is awarded if, after completing training on how to use the family day care rating scale, the provider completes a self-assessment using the family day care rating scale.

(3) One point is awarded if, after completing training on how to use the family day care rating scale, the provider completes Form 470-4232, Child Development Home Improvement Plan, based on the family day care rating scale self-assessment.

b. Environment rating scale. A home may earn a maximum of two points on the environment rating scale. An assessor approved by the department of human services or the department's designee must perform the environment rating assessment. The provider must complete training on the family day care rating scale before requesting assessment. Points are awarded as follows:

(1) One point is awarded if the home receives an average score of 4 on a scale of 7, with no subscale scores lower than 2.

(2) Two points are awarded if the home receives an average score of 5 on a scale of 7, with no subscale scores lower than 2.

c. Accreditation. Three points are awarded if the home is accredited by the National Association for Family Child Care or another accrediting body approved by the department of human services.

118.4(5) *Family and community partnerships.* A child development home may earn a maximum of two points in the family and community partnerships category. Points are awarded as follows:

a. One point is awarded if the provider is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the provider offers an orientation for new parents and holds annual conferences with parents.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.5(237A) Rating standards for child care centers, preschools, and programs operating under the authority of an accredited school district or nonpublic school. To participate in the quality rating system, a child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school applying under subrule 118.2(2) shall certify that its facility meets the applicable criteria as defined in subrule 118.5(1).

118.5(1) *Criteria.* Criteria for each rating level are defined as follows:

a. Level 1. To be rated at Level 1, a facility must either:

(1) Have a full or provisional license from the department with no action pending to revoke or deny the license; or

(2) Operate under the authority of an accredited school district or nonpublic school.

b. Level 2. To be rated at Level 2, a facility must meet the following criteria:

(1) The facility must have a full license from the department with no action pending to revoke or deny the license or must operate under the authority of an accredited school district or nonpublic school.

(2) If eligible, the facility must participate in the child and adult care food program (CACFP), unless children are in attendance less than four hours per day and the program does not serve meals.

(3) The facility must have on duty in each room at all times at least one staff member who has completed training in mandatory reporting of child abuse, universal precautions and infectious disease control, cardiopulmonary resuscitation, and first aid as specified in 441—subrule 109.7(1) and subparagraphs 109.7(2)*"a"*(1) and (2).

(4) The facility must provide basic orientation for all staff before they begin work.

(5) All staff, including the facility's director, must complete Form 470-4234, Child Care Center Staff Self-Assessment, no more than 12 months before application for quality rating. The director must also complete Form 470-4233, Child Care Center Self-Assessment.

c. Level 3. To be rated at Level 3, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 17 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

d. Level 4. To be rated at Level 4, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 27 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

e. Level 5. To be rated at Level 5, a facility must meet the following criteria in addition to meeting the criteria for Level 2:

(1) The facility must earn a minimum of 34 points from the categories listed in subrules 118.5(2) through 118.5(6).

(2) The facility must earn at least one point from each category.

(3) The facility must earn a minimum score of 5.0 in each assessed classroom on the appropriate environment rating scale. An assessor approved by the department or the department's designee must perform the environment rating assessment. At least one-third of the facility's classrooms must be assessed, including at least one classroom in each age group served by the facility.

118.5(2) *Professional development.* A maximum of 30 points may be earned in the professional development category. Points are awarded as follows:

a. Credential. A maximum of five points may be earned in the credential category.

(1) Five points are awarded if the facility director has a current national administrator credential or Aim4Excellence credential.

(2) Five points are awarded if the facility director is a school principal licensed by the Iowa board of educational examiners.

(3) Five points are awarded if a staff member has completed the two-year Head Start management acceleration program covering all aspects of Head Start management, services and systems.

b. Education and experience. A maximum of 25 points may be earned for education and experience. To arrive at the total number of points earned, each staff member shall indicate the highest applicable education and experience qualification. Points will be assigned for each staff member based on the following criteria, and the total points will be divided by the number of staff. Only one criterion may be scored for each staff member.

(1) Has a master's degree in education appropriate to the age group for whom care is provided: 25 points.

(2) Has a bachelor's degree in education appropriate to the age group for whom care is provided: 20 points.

(3) Has an associate's degree in education appropriate to the age group for whom care is provided: 10 points.

(4) Has a one-year diploma in education appropriate to the age group for whom care is provided: 8 points.

(5) Has an apprenticeship certificate: 7 points.

(6) Has a child development associate credential: 6 points.

(7) Has an Iowa board of educational examiners paraeducator certificate at Level 2, early childhood, plus two years of experience in early childhood education under the supervision of a licensed early childhood teacher: 6 points.

(8) Has nine college credit hours in education specific to the age group for whom care is provided: 5 points.

(9) Has 30 hours of annual approved training beyond regulatory requirements and at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school: 4 points.

(10) Has 15 hours of annual approved training beyond regulatory requirements: 2 points.

118.5(3) *Health and safety.* A maximum of 19 points may be earned in the health and safety category. Points are awarded as follows:

a. Five points are awarded if within the five-year period before the application date the center director, assistant director, or on-site supervisor has successfully completed a three-semester-hour health, safety, and nutrition class through an approved community college or four-year college.

b. Two points are awarded if within the two-year period before the application date the center director, assistant director, or on-site supervisor has successfully completed a health and safety training approved by the department for the specific purpose of awarding points in the quality rating system.

c. Two points are awarded if the provider develops and implements an emergency preparedness plan in a format prescribed by the department.

d. Two points are awarded if the provider develops and implements enhanced health and safety policies in a format prescribed by the department.

e. Up to three points may be awarded for injury prevention.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

f. Up to two points may be awarded for child record review.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

g. Up to three points may be awarded for health and safety assessment.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.5(4) *Environment.* A maximum of 27 points may be earned in the environment category. Points are awarded as follows:

a. Training and self-assessment. A maximum of nine points may be earned in training and self-assessment.

(1) Two points are awarded if the facility director or assistant director completes approved training on the use of the infant/toddler environment rating scale, the early childhood environment rating scale, or the school-age care environment rating scale to evaluate and improve the facility before outside evaluation.

(2) Two points are awarded if, after completing approved training on how to use the environment rating scale, the facility director or assistant director completes a self-assessment and score sheet of at least one-third of the facility's classrooms, including at least one classroom in each age group served by the facility using the applicable environment rating scale.

(3) Two points are awarded if, after completing approved training on how to use the environment rating scale, the facility director or assistant director completes Form 470-4288, Child Care Center Improvement Plan, based on the environment rating scale self-assessment. Form 470-4288 must be completed for each room for which a self-assessment was completed.

(4) Three points are awarded if, after completing approved training on Iowa quality preschool program standards, the facility director or assistant director completes the Iowa quality preschool program standards self-assessment and develops a quality improvement plan.

b. Enhanced ratios. A facility may earn a maximum of three points for enhanced staff-to-child ratios. Three points are awarded if the facility meets accreditation standards for group or class size and staff-to-child ratio from an accrediting body identified at subparagraph 118.5(4)*"d"*(3) that is appropriate to the child care setting. These points may not be awarded to programs receiving points under subparagraph 118.5(4)*"d"*(3).

c. Accreditation preparation. A facility may earn a maximum of five points for accreditation preparation. Five points are awarded if the facility's accreditation self-assessment is approved by the National Association for the Education of Young Children. These points may not be awarded to programs receiving points under subparagraph 118.5(4)*"d"*(3).

d. Accreditation. A facility may earn a maximum of 18 points for accreditation. Points are awarded for one of the following criteria:

(1) Five points are awarded if the program is verified by the Iowa quality preschool program standards.

(2) Six points are awarded if a Head Start program demonstrates compliance with Head Start program performance standards.

(3) Eighteen points are awarded if the facility is accredited by the National Association for the Education of Young Children, the National Afterschool Association, or another accrediting body approved by the department.

118.5(5) *Family and community partnerships.* A maximum of eight points may be earned in the family and community partnership category. Points are awarded as follows:

a. One point is awarded if the facility or the facility director is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the facility provides orientation for new parents.

c. One point is awarded if the facility holds annual conferences with parents.

d. One point is awarded if the facility holds at least one parent meeting annually.

e. Two points are awarded if a parent advisory board coordinated by the facility meets quarterly.

f. Two points are awarded if the facility collects annual parent surveys and uses the results to inform program practices.

118.5(6) *Leadership and administration.* A maximum of seven points may be earned in the leadership and administration category. Points are awarded as follows:

a. Two points are awarded if the facility completes yearly written evaluations for all staff.

b. One point is awarded if the facility develops an improvement plan using Form 470-4235, Child Care Center Improvement Plan, and updates the form annually.

c. One point is awarded if all staff complete Form 470-4236, Professional Development Plan.

d. Three points are awarded if all staff who have direct contact with children complete one of the following within four months of beginning employment with the facility:

(1) The new staff orientation training delivered by Iowa state university that provides new center and preschool staff a full, program-based orientation, or

(2) Another curriculum approved by the department.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.6(237A) Rating criteria for child development homes. To participate in the quality rating system, a child development home provider applying under subrule 118.2(2) shall certify that the home meets the applicable criteria as defined in subrule 118.6(1).

118.6(1) *Criteria for each rating level.*

a. Level 1. To be rated at Level 1, the home must be a registered child development home.

b. Level 2. To be rated at Level 2, the home must meet the following criteria in addition to meeting the criterion for Level 1:

(1) The provider completes and maintains ChildNet certification.

(2) The provider participates in the child and adult care food program (CACFP).

(3) The provider completes Form 470-4231, Child Development Home Professional Development Self-Assessment.

(4) The provider completes Form 470-4236, Professional Development Plan.

c. Level 3. To be rated at Level 3, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 14 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

d. Level 4. To be rated at Level 4, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 19 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

e. Level 5. To be rated at Level 5, the home must meet the following criteria in addition to meeting the criteria for Levels 1 and 2:

(1) The home must earn a minimum of 25 points from the categories listed in subrules 118.6(2) through 118.6(5).

(2) The home must earn at least one point from each category.

(3) The home must earn a minimum score of 5.0 on the family child care environment rating scale. An assessor approved by the department or the department's designee must perform the assessment.

118.6(2) *Professional development.* A child development home may earn a maximum of 34 points in the professional development category. For child development homes registered as Category C, points will be awarded only to the coprovider who has earned the most points. Points are awarded as follows:

a. Experience and training. A home may earn a maximum of four points for experience and training. Points are awarded as follows:

(1) Two points are awarded if the provider has at least two years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 10 hours of additional training per year beyond regulatory requirements.

(2) Four points are awarded if the provider has at least five years of experience working in a child care facility or a program operating under the authority of an accredited school district or nonpublic school and 20 hours of additional training per year beyond regulatory requirements.

b. Additional professional development. A home may earn a maximum of five points for additional professional development. Points are awarded as follows:

(1) Two points are awarded if the provider successfully completes approved modules 1 and 2 of positive behavior and intervention support training developed by the Center on Social and Emotional Foundations for Learning (CSEFEL). Modules 1 and 2 total a minimum of 12 hours of training which focuses on promoting effective classroom and center practices that enhance the social and emotional competency of young children.

(2) Three points are awarded if the provider successfully completes modules 1 through 4 of the program for infant and toddler care developed by WestEd and the California Department of Education, covering social-emotional growth and socialization, group care, learning and development, culture, and family and providers.

c. Education. A home may earn a maximum of 25 points for education. Points are awarded for one of the following criteria:

(1) Twenty-five points are awarded if the provider has completed a master's degree in education appropriate to the age group for whom care is provided.

(2) Twenty points are awarded if the provider has completed a bachelor's degree in education appropriate to the age group for whom care is provided.

(3) Ten points are awarded if the provider has completed an associate's degree in education appropriate to the age group for whom care is provided.

(4) Eight points are awarded if the provider has completed a one-year diploma in education appropriate to the age group for whom care is provided.

(5) Seven points are awarded if the provider has a current apprenticeship certificate.

(6) Six points are awarded if the provider has a current child development associate credential.

(7) Five points are awarded if the provider has completed at least nine college credit hours in education specific to the age group for whom care is provided.

118.6(3) *Health and safety.* A child development home may earn a maximum of 19 points in the health and safety category. Points are awarded as follows:

a. Five points are awarded if within the five-year period before the application date the provider successfully completes a three-semester-hour health, safety, and nutrition class through an approved community college or four-year college.

b. Two points are awarded if within the two-year period before the application date the provider successfully completes a health and safety training approved by the department for the specific purpose of awarding points in the quality rating system.

c. Two points are awarded if the provider develops and implements an emergency preparedness plan in a format prescribed by the department.

d. Two points are awarded if the provider develops and implements enhanced health and safety policies in a format prescribed by the department.

e. Up to three points may be awarded for injury prevention.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-IP2006, Injury Prevention Summary Report, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has started the process of making recommended corrections.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

f. Up to two points may be awarded for child record review.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-CRR2006, Child Record Review, during a visit with a child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has worked with the child care nurse consultant to refer families to health care providers.

g. Up to three points may be awarded for health and safety assessment.

(1) One point is awarded if the facility completes the Iowa department of public health's Form HCCI-HSA2006, Health and Safety Assessment, during a visit with the child care nurse consultant.

(2) Two points are awarded if the child care nurse consultant verifies that the facility has developed a plan of action to correct deficiencies.

(3) Three points are awarded if the child care nurse consultant verifies that the facility has completed all corrections.

118.6(4) *Environment.* A child development home may earn a maximum of 23 points in the environment category. Points are awarded as follows:

a. Environment rating scale training and self-assessment. A home may earn a maximum of six points for environment rating scale training and self-assessment. Points are awarded as follows:

(1) Two points are awarded if the provider completes approved training on how to use the family child care environment rating scale to assess the child development home environment.

(2) Two points are awarded if, after completing training on how to use the environment rating scale, the provider completes a self-assessment and score sheet using the environment rating scale.

(3) Two points are awarded if, after completing training on how to use the environment rating scale and completion of the environment rating scale self-assessment and score sheet, the provider completes Form 470-4232, Child Development Home Improvement Plan, based on the environment rating scale self-assessment.

b. Enhanced ratios. A home may earn a maximum of two points for enhanced staff-to-child ratios. Two points are awarded if no more than two children under the age of two are in care at any one time and no more than six children total are in care at any one time, including the provider's own children under school age.

c. Accreditation. A home may earn a maximum of 15 points for accreditation. Fifteen points are awarded if the home is accredited by the National Association for Family Child Care or another accrediting body approved by the department.

118.6(5) *Family and community partnerships.* A child development home may earn a maximum of six points in the family and community partnership category. Points are awarded as follows:

a. One point is awarded if the provider is a member of a professional organization specific to the age group for whom care is provided.

b. One point is awarded if the provider offers an orientation for new parents.

c. One point is awarded if the provider holds annual conferences with parents.

d. One point is awarded if the provider holds at least one parent meeting annually.

e. Two points are awarded if the provider collects annual parent surveys and uses the results to inform program practices.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.7(237A) Award of quality rating.

118.7(1) The facility shall display Form 470-4230, Quality Rating Certificate, in a conspicuous place.

118.7(2) Achievement bonuses may be awarded as funds are available.

118.7(3) Participants may request another quality rating for the purpose of increasing their rating no sooner than 12 months after issuance of a quality rating certificate.

118.7(4) Ratings are effective for 24 months from the date of issuance.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

441—118.8(237A) Adverse actions.

118.8(1) An eligible applicant must be notified of the right to appeal the rating decision in accordance with 441—Chapter 7.

118.8(2) A participant's quality rating shall be revoked if the facility no longer meets the definition of "eligible applicants."

118.8(3) Form 470-4230, Quality Rating Certificate, shall be returned to the department of human services if:

a. The certificate is revoked;

b. The certificate is not renewed; or

c. The provider voluntarily withdraws from the program.

118.8(4) Ratings are effective for 24 months from the date of issuance.

[**ARC 9257B**, IAB 12/1/10, effective 2/1/11]

DIVISION II
IOWA QUALITY FOR KIDS (IQ4K)

PREAMBLE

Division II of this chapter establishes rules for the IQ4K rating system and Iowa's quality rating and improvement system (QRIS) for child care providers. Participation in IQ4K is voluntary. Division II includes application procedures and standards to guide the quality rating process. The rules in Division II are in effect for new applications for child care providers applying for the IQ4K program.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.9(237A) Definitions.

"Action plan" means a written, detailed sequence of steps taken or activities performed to reach one or more goals.

"All staff" means program administrator or director, assistant program administrator or assistant director, on-site supervisor, lead teacher and staff counted as part of the staff-to-child ratio.

"Area education agency" or *"AEA"* means an agency working as an educational partner with public and accredited nonpublic schools to help learners, school staff, parents and communities. AEAs provide early intervention services, special education support services, media and technology services, a variety of instructional services, professional development and leadership to promote school improvement as established in Iowa Code chapter 273.

"Assessment tool" means a tool used to gather and provide educators, parents, guardians, and caretakers with critical information about a child's educational growth and development. Assessment tools are used to determine what children in care know, understand and are able to do. Assessment results drive the ways teachers support and assess children's learning, plan their curriculum to support each child, monitor progress and identify next steps.

"Assistant program administrator" or *"assistant director"* means the staff member working directly under the administrator or director and assisting with program planning, managing, marketing and directing.

"Assistant teacher" means any staff member working under the supervision of a lead teacher or other licensed personnel who has the ultimate responsibility for the design and implementation of education and related service programs. Other terms used may include paraprofessional, educational aide, associate, or instructional aide.

"Caring for our children" or *"CFOC"* means the national health and safety performance standard guidelines for early care and education programs representing the best practices based on evidence, expertise, and experience for quality health and safety policies for early care and education settings.

"Child and adult care food program" or *"CACFP"* means a federal United States Department of Agriculture (USDA) CNP that provides a subsidy for serving nutritious meals and snacks to eligible children and adults who are enrolled at participating child care centers, homes, and adult day care centers. CACFP also provides reimbursements for meals served to children and youth participating in afterschool care programs, children residing in emergency shelters, and adults over the age of 60 or living with a disability and enrolled in adult day care facilities. In order to qualify for reimbursement, the meals served must meet federal guidelines.

"Child care experience" means knowledge and skills learned through employment or volunteer work in a licensed child care center, a school-aged only program, a preschool, a registered child development home or as a child care home provider.

"Child care nurse consultant" or *"CCNC"* means a registered nurse licensed in the state of Iowa who has completed training incorporating the nationally approved child care health competencies for health and safety in child care and early education. The CCNC provides on-site consultation, technical assistance, care planning for children with special health needs and training to child care and early education providers regarding health and safety. The CCNC is employed by or has a written agreement with the local Title V maternal and child health agency or the Iowa department of public health (IDPH) for service delivery directly through the state-level Title V maternal and child health program administered by the IDPH bureau of family health.

"Child care resource and referral" or *"CCR&R"* means the statewide (regionally based) agency focused on supporting quality child care throughout the state of Iowa. CCR&R serves as the starting point for all IQ4K applications and provides free technical assistance and consultation to providers throughout the IQ4K application process.

"Child development associate credential" or *"CDA"* means a nationally recognized credential earned by individuals working in the early child care and education field. The CDA credential is based on a core set of competency standards and includes an assessment process by the Council for Professional Recognition.

"Child development home" means a person or program registered under Iowa Code section 237A.3A that may provide child care to seven or more children at any one time.

"ChildNet certification" means a verified completion of the 25-hour ChildNet training series and completion of the certification process.

"ChildNet training" means the 25-hour training series offered through CCR&R focused on areas specifically designed for child development home providers.

"Child nutrition programs" or *"CNP"* means federally funded programs administered by the Food and Nutrition Service (FNS). The programs are designed to help ensure that children receive nutritious meals and snacks to assist in promoting health and educational readiness. Programs serving nutritious meals and snacks are reimbursed for participating.

"Classroom assessment scoring system" or *"CLASS"* means an observation instrument that assesses the quality of teacher-child interactions in center-based classrooms.

"Community resources" means the various people, places or services that offer support to child care programs and the children and families they serve.

"Coprovider" means a second approved provider in a Category C registered child development home.

"Culturally sensitive" means the knowledge, skills, attributes and beliefs that enable people to work well with, respond effectively to and be supportive of people in a cross-cultural setting.

"Curriculum" means a written plan that outlines how students shall be taught. The curriculum consists of the plans for the learning experiences through which children acquire knowledge, skills, abilities, and understanding. The curriculum may include lessons, instructional materials, teaching techniques, or activities.

"Department" means the Iowa department of human services.

"Developmental screening tool" means a research-based questionnaire or checklist that asks questions about a child's development, including but not limited to language, movement, thinking, behavior and emotions. Developmental screening shall not be used to establish a diagnosis for a child but rather to help educators, parents, guardians or caretakers determine whether more in-depth assessment may be the next appropriate step.

"Early childhood-positive behavioral interventions and supports" or *"EC-PBIS"* means Iowa's pyramid model initiative which offers early childhood programs a comprehensive, evidence-based approach to promoting social-emotional development and addressing challenging behaviors among young children. EC-PBIS creates nurturing environments for children equipped with supported staff trained to respond to challenging behaviors to support the goal of fostering positive mental health at a young age.

"EC-PBIS module training" means a series of training intended for staff working with young children. The training teaches the pyramid model, which is a framework of evidence-based practices for promoting young children's healthy social and emotional development. There are different versions of the training depending on what setting and what age group the staff member is working with. Versions include:

1. EC-PBIS for Preschool (modules 1-3) intended for staff working in classroom-based programs with ages three to five.
2. EC-PBIS for Infants and Toddlers (modules 1-3) intended for staff working in classroom-based programs with ages zero to three.
3. EC-PBIS for Family Child Care (modules 1-2) intended for staff working with multiple ages of children in family child care settings.

"Eligible applicants" means programs meeting the definition of "facility."

"Environment rating scale" or *"ERS"* means a set of early childhood tools or scales developed through the Frank Porter Graham Child Development Institute of the University of North Carolina at Chapel Hill. The scales are used to measure classroom and program quality through assessments by a trained, independent observer. The scales may also be used for self-assessment and program improvement. Four scales are available based on the type of program and ages of children in the classroom assessed:

1. Family child care environment rating scale (FCCERS) for programs in a family child care or child development home setting for children from infancy through school age.
2. Infant and toddler environment rating scale (ITERS) for groups of children in center-based care from birth up to three years of age.
3. Early childhood environment rating scale (ECERS) for center-based care with groups of children aged three through five years.
4. School-age care environment rating scale (SACERS) for center-based programs with groups of school-age children aged 5 through 12 years.

"ERS assessment" means an evaluation conducted through an on-site observation of an early childhood care and education classroom or program using one of the environment rating scales: FCCERS, ITERS,

ECERS, or SACERS. The assessment is completed by a trained assessor and administered by entities approved by the department or the department's designee.

"ERS improvement plan" means the action plan created by a program or classroom to lay out ideas for improving program quality. It uses a framework based on ERS criteria and definitions. The ERS improvement plan follows and builds upon a completed ERS classroom or program self-assessment using the appropriate ERS.

"ERS score sheet" means the form used to evaluate and score a program or classroom based on the ERS items and indicators.

"Facility" means a licensed child care center, a preschool, a program operating under the authority of an accredited school district or nonpublic school, or a registered child development home.

"Full-time child care experience" means knowledge and skills learned through employment or volunteer work, at least 30 hours per week or 130 hours per month, in a licensed child care center, a school-aged only program, a preschool, or a registered child development home or as a child care home provider.

"Head Start program performance standards" means the mandatory regulations that grantees and delegate agencies must implement in order to operate a Head Start program. The performance standards are designed to ensure that Head Start goals and objectives are implemented successfully.

"Health and safety checklist for early care and education (ECE) programs" means the nationally recognized quality assessment tool, conducted by a CCNC or another designee as approved by the department, that uses key observable health and safety standards from CFOC. If followed, these standards are most likely to prevent adverse outcomes for children and staff in ECE settings. For the health and safety checklist, "observable" is defined as the following:

1. Requires interaction with the staff or director only to ask where to find an item or identify products.
2. Able to observe when walking through a program over a two-hour period of time.
3. The standard or item can be seen and evaluated in an objective way.
4. Observation may include opening windows, taking measurements (for example, measuring the depth of an impact surface or height of equipment), smelling for odors and reading labels (for example, checking dates on medication labels).
5. Does not require checking records or documents, such as child immunizations, professional development records or written program policies.

"Internal coach" means the staff member, identified by the program administrator, responsible for going into classrooms and supporting staff on the implementation of the EC-PBIS policies and practices. The internal coach shall be a member of the program's positive behavioral interventions and supports (PBIS) leadership team.

"Iowa early care and education program administrator roles career pathway" means the statewide professional development path (www.ecieducationpathway.org) designed to assist early childhood center administrators or other early childhood leaders to develop a personal professional development plan as an early childhood educator II or early childhood educator III.

"Iowa early care and education teaching roles career pathway" means the statewide professional development path (www.ecieducationpathway.org) designed to assist early childhood teachers in a licensed center or a child development home to develop a personal professional development plan as an early childhood educator I, an early childhood educator II or an early childhood educator III.

"Iowa early learning standards" or *"IELS"* means a comprehensive resource tool developed to support and enhance children's learning and development. The IELS provides descriptions of the knowledge, behaviors and skills that children from birth through age five may demonstrate and can be used to share information with anyone who cares for or works with children during the first 2,000 days of life.

"Iowa quality preschool program standards" means standards developed by the Iowa department of education based on the ten standards of the National Association for the Education of Young Children accreditation.

"IQ4K teaching staff qualifications worksheet" means the tool used to calculate an average score in the area of teaching staff qualification using a combination of the educational background and related work experience of identified teaching staff members.

"Leadership team" means the team of people that is working to implement a programwide EC-PBIS. The team is composed of program administrators, teachers and a coach. The leadership team is responsible for guiding the programwide process and making decisions on how to support implementation of the EC-PBIS practices throughout the whole program.

"Lead teacher" means the staff member responsible for providing a safe and developmentally appropriate classroom that complies with legislation, policies, and procedures. The lead teacher nurtures children, plans and provides instruction and other activities, ensures student safety, directs the work of other teachers in the classroom, communicates with parents and guardians, is familiar with emergency procedures, and ensures children with diverse needs are included and have their needs met at all times.

"Meals" means any breakfasts, lunches, snacks and suppers the child care program serves to children while in care.

"National Administrator Credential" or *"NAC"* means the 40-hour comprehensive training for child care and education administrators and successful completion of the certification process offered through the National Early Childhood Program Accreditation (NECPA) Commission.

"National School Lunch Program" or *"NSLP"* means a federal CNP operating in public and nonprofit private schools and residential child care institutions. The NSLP provides nutritionally balanced, low-cost or no-cost lunches to children each school day.

"On-site supervisor" means the individual responsible for the daily supervision of the program who must be on site daily, either during the hours of operation that children are present or at a minimum of eight hours of the program's hours of operation.

"Prevent-Teach-Reinforce for Young Children" or *"PTR-YC"* means the training based on the PTR-YC process for use in early childhood care and education settings including pre-K classrooms and consists of teams and goal setting, practical data collection, functional behavioral assessment, intervention planning and implementation. All steps are designed for use by early childhood providers.

"Professional development plan" means the individualized plan used to improve knowledge and skills. Professional development plans shall address the following:

1. Assessment of an individual's current interests, knowledge and skills.
2. Identification of specific areas for improvement.
3. Development of strategies and resources.
4. Creation of opportunities to reflect and demonstrate an individual's professional growth.

"Professional development training" means continuing education and career training offered by a department-approved training organization to child care and education providers to help them develop new skills, stay up to date on current trends and advance their careers.

"Program" refers to the complete operation of an eligible facility applying for an IQ4K rating.

"Program administrator or director" means a department-approved staff member responsible for overseeing the day-to-day operations of a child care program. The person is in charge of all aspects of running the program, including scheduling trainings, planning educational activities, hiring and managing properly trained staff, handling the budget, and establishing well-defined policies and procedures. The person is responsible for everything that takes place within the program and acts as the main communication hub between parents, teachers and children.

"Programwide PBIS training" or *"PW PBIS training"* means the training intended for leadership teams of classroom-based early childhood programs. The purpose of the training is to help guide and support the leadership team through the programwide EC-PBIS process.

"Provider" means the person or program that applies for registration to provide child care and is approved as a child development home.

"Quality rating oversight team" means the workgroup convened to provide oversight and guidance to the department regarding Iowa's QRIS.

"School-aged only program" means an eligible facility providing care primarily to children aged 5 through 12 when school is not in session, including but not limited to before school, after school, out-of-school days during the school year and summer break.

"Seamless summer option" or *"SSO"* means a federal CNP which allows school food authorities participating in the National School Lunch or School Breakfast Program to serve meals free of charge to children 18 years and under from low-income areas.

"Self-assessment" means an evaluation of current program policies, practices and procedures in comparison to best-practice standards based on the most up-to-date research.

"Social-emotional-behavioral mental health" or *"SEBMH"* means the way in which an individual thinks, feels, communicates, acts and learns. These skills contribute to resilience and to how individuals relate to others, respond to stress and emotions, and make choices. Foundational knowledge and skills that promote positive SEBMH include self-awareness, self-management, responsible decision-making, social awareness, and relationship skills that support positive well-being and academic success.

"Specialized track" means a modified IQ4K application for eligible applicants who have successfully provided adequate documentation of current verification and certification in one of the department's preapproved specialized track areas.

"Staff" means any individual employed by and working at the facility under the supervision of the program administrator or director or assistant program administrator or assistant director.

"Summer food service program" or *"SFSP"* means a federal CNP that reimburses program operators who serve free healthy meals and snacks to children 18 years and under from low-income areas.

"Teaching staff" means all lead teachers and assistant teachers.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.10(237A) Application for Iowa quality for kids (IQ4K) rating. Eligible applicants shall apply for an IQ4K rating by completing the appropriate application and submitting all required supporting documentation.

118.10(1) *Standards to be used.* The quality rating will be based on the standards in rules 441—118.21(237A) through 441—118.25(237A) for a child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school; rules 441—118.27(237A) through 441—118.31(237A) for school-aged only programs; and rules 441—118.33(237A) through 441—118.37(237A) for child development homes.

118.10(2) *Application for IQ4K.* All applications must be accessed, completed and submitted to the applicant's designated CCR&R representative through the IQ4K database located at iq4k.stateofiowadhs.org/login.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.11(237A) Application effective date. The effective date of an approved IQ4K application shall be determined as listed in these subrules.

118.11(1) *New or nonrated applicant, Levels 1-4.* The application effective date will be the day the department certifies the application is complete and makes the appropriate award determination.

118.11(2) *New or nonrated applicant, Level 5.* The application effective date will be the day the department confirms the program's scores on the ERS and subsequently makes the appropriate award determination. The effective date of a program whose assessment opportunity has been forfeited, as outlined in rule 441—118.25(237A), shall be the date the department determined the assessment opportunity was forfeited.

118.11(3) *Currently rated applicant, Levels 1-4.* If the program's new application is submitted prior to the IQ4K expiration date, the new application's effective date shall be the first day of the month following the program's current expiration date.

118.11(4) *Currently rated applicant, Level 5.* If the program's new application is submitted 30 calendar days prior to the IQ4K expiration date, the new application's effective date shall be the first day of the month following the program's current expiration date.

a. If the program's new application is not submitted 30 calendar days prior to the IQ4K expiration date, the new application effective date will be the day the department confirms the program's scores on the ERS and subsequently makes the appropriate award determination.

b. If the ERS process is not complete by the time of the program's IQ4K expiration date, the program's IQ4K rating will expire and the program will not have an IQ4K rating until the ERS process is complete and a new IQ4K rating is determined.

c. The effective date of a program whose assessment opportunity has been forfeited, as outlined in rule 441—118.25(237A), shall be the date the department determined the assessment opportunity was forfeited.

118.11(5) *Currently rated applicant, mid-rating increase to Levels 2-4.* The application effective date will be the day the department certifies the application is complete and makes the appropriate award determination.

118.11(6) *Currently rated applicant, mid-rating increase to Level 5.* The application effective date will be the day the department confirms the program's scores on the ERS and subsequently makes the appropriate award determination. The effective date of a program whose assessment opportunity has been forfeited, as outlined in rule 441—118.25(237A), shall be the date the department determined the assessment opportunity was forfeited.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.12(237A) Approved program's expiration date. An approved program's IQ4K expiration date shall be the last day of the month, two years from the application's effective date.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.13(237A) Renewal application submission, Levels 1-4. Eligible applicants may submit an application for IQ4K renewal up to 45 calendar days in advance of the current IQ4K expiration date.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.14(237A) Renewal application submission, Level 5. Eligible applicants may submit an application for IQ4K renewal up to 60 calendar days in advance of the current IQ4K expiration date.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.15(237A) Increased rating. Currently rated IQ4K programs may submit an application for a higher quality rating no sooner than 12 months after the effective date of the current IQ4K certificate.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.16(237A) Change in location of facility. If the location of a rated program changes, the program must notify the department. The program's current IQ4K rating will be invalid, and the program must submit a new application. The department shall make a new determination of the appropriate rating.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.17(237A) Ongoing eligibility. All applicants awarded an IQ4K certification level must continue to meet all eligibility requirements of the awarded level throughout the entire certification period.

118.17(1) Programs unable to maintain full compliance with all eligibility requirements at their awarded level may apply for a waiver of eligibility within 30 calendar days of their inability to do so.

118.17(2) Waivers shall be awarded at the discretion of the department, in consultation with the quality rating oversight team.

118.17(3) Programs that are not able to meet all eligibility requirements of the awarded level throughout the entire certification period or that do not receive a waiver will have their IQ4K rating removed immediately.

118.17(4) Provisionally licensed programs are not eligible to apply for IQ4K participation.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.18(237A) Monitoring. Programs awarded an IQ4K rating shall agree to scheduled on-site and virtual program monitoring by the department or the department's designee to confirm and review compliance with criteria of awarded IQ4K rating.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.19(237A) Professional development training. Only training taken from a department-approved training organization shall be accepted toward professional training requirements. Secondary education credits shall count as one secondary education credit equaling 15 training hours based on ages of the children served in the program.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.20(237A) Rating standards for a child care center, a preschool, or a program operating under the authority of an accredited school district or nonpublic school. To participate in IQ4K QRIS, a child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school shall certify that its facility meets the applicable criteria as defined in rules 441—118.21(237A) through 441—118.25(237A).

118.20(1) Eligible applicants providing adequate documentation of current verification or certification in one of the preapproved specialized track areas shall only be required to satisfy the criteria outlined in the application consistent with their specialized track.

118.20(2) Programs with more than one classroom shall not be eligible to apply using a specialized track application unless over 50 percent of their eligible classrooms meet the specialized track requirements.

118.20(3) Eligible applicants shall be able to earn credit for participation in more than one of the specialized track areas.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.21(237A) Criteria for IQ4K—Level 1 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school. To be rated at a Level 1, an eligible facility must satisfy all of the criteria in each of the seven designated categories listed in Level 1 or complete all of the criteria designated in its respective specialized tracks.

118.21(1) *Nutrition and physical activity.*

a. All staff members who prepare meals shall complete one of the department-approved food safety trainings.

b. A self-assessment and action plan in the area of nutrition shall be completed for an eligible facility.

c. A self-assessment and action plan in the area of physical activity shall be completed for an eligible facility.

118.21(2) *Professional development.*

a. All staff shall complete a professional development plan within six months of each person's hiring date and update the plan annually.

b. All staff shall complete one of the department-identified new staff orientation courses and must provide a valid certificate of completion. Newly hired staff shall have nine months from date of hire to complete this requirement.

118.21(3) *Family and community partnerships.*

a. The program shall provide an orientation for new families.

b. The program shall complete one annual activity that promotes partnerships.

118.21(4) *Teaching staff qualifications.* All lead teachers shall show participation in Tier 1 training or meet a higher tier qualification on the Iowa early care and education teaching roles career pathway within six months of starting employment.

118.21(5) *Teaching and learning.*

a. The program administrator and at least one lead teacher shall complete two hours of training on the Iowa early learning standards.

b. The program shall develop and implement a comprehensive discipline and behavior policy that promotes positive relationships.

118.21(6) *Environment.*

a. The program shall develop and implement, as applicable to ages served, the following policies aligned to CFOC:

(1) Supervision.

(2) Safe sleep.

(3) Playground equipment stability and fall surfacing and inspection.

(4) Missing child.

(5) Strangulation prevention.

(6) Sign in and out tracking system for children and visitors.

b. The program shall submit one of the following annually:

(1) Form 470-5676: IQ4K Interaction and Relationship Self-Assessment, which shall be completed by teaching staff.

(2) CLASS assessment for the age level being served completed for each classroom by a trained observer.

(3) Teaching pyramid observation tool (TPOT) or teacher pyramid infant toddler observation scale (TPITOS) assessment tools for infants and toddlers completed for each classroom by a trained observer.

118.21(7) *Leadership and administration.*

a. All staff shall complete Form 470-5680: IQ4K Staff Self-Assessment annually.

b. The program administrator shall complete Form 470-5677: IQ4K Program Assessment annually.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.22(237A) Criteria for IQ4K—Level 2 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school. To be rated at a Level 2, an eligible facility must satisfy all of the criteria in each of the seven designated categories listed in Levels 1 and 2 or complete all of the criteria designated in its respective specialized tracks for Levels 1 and 2.

118.22(1) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP, NSLP, or another department-approved CNP.

(2) The program shall complete all of the following as applicable to ages served:

1. Program staff and their supervisor planning the menu shall complete the CACFP Steps to Success module 2 lessons as identified by the department that cover the CACFP meal pattern.

2. Infant lead teachers and their supervisor shall complete the video "CACFP Child Care Center Infant Staff Training" or Iowa CACFP Infant Training—Steps to Success module 15, parts as identified by the department.

3. All lead teachers and their supervisors responsible for mealtime supervision shall complete the video "CACFP Child Care Center Staff Training" or the Iowa CACFP Wellness module—Meaningful Mealtimes.

b. The program shall identify and implement one physical activity goal from the completed action plan in Level 1.

118.22(2) *Professional development.*

a. All staff who administer medication shall complete the Medication Administration Skills Competency Course or other training as approved by the department and hold a valid certification of completion.

b. All staff who administer medication shall also successfully complete a competency skills evaluation assessment checklist or department-approved equivalent and hold a valid certification of completion. There shall be one person who meets these criteria present on site in the program at all times.

c. All teaching staff shall complete ten annual training hours of professional development.

118.22(3) *Family and community partnerships.*

a. The program shall offer one conference with each family per year to discuss each child's progress, strengths, and needs in all developmental areas.

b. Programs shall share child assessment information with the child's family.

c. The program shall complete two activities annually that promote partnerships.

118.22(4) *Teaching staff qualifications.* All lead teachers shall meet Tier 1, step 1 of 40 hours of training toward a CDA or shall meet a higher tier qualification on the Iowa early care and education teaching roles career pathway.

118.22(5) *Teaching and learning.*

a. The program shall use a curriculum that is aligned with the Iowa early learning standards, addresses the multiple domain areas, and is specific to the ages of the children the program serves.

b. The program shall develop and implement a policy that eliminates or severely limits expulsion, suspension, and punitive or other exclusionary discipline.

c. The program shall develop and implement policies regarding the use of an approved developmental screening tool for all children within 60 days of enrollment and at least annually to identify children who may need additional evaluation and intervention strategies.

118.22(6) *Environment.*

a. The program administrator or assistant administrator shall complete an ERS training, choosing between ITERS, ECERS or SACERS, and provide a certificate of completion.

b. The program shall provide an environment supportive to, and encouraging of, culture, age, race, ability, special needs, and gender diversity.

c. The program shall develop and implement a tobacco-free and nicotine-free policy aligned to the Iowa department of public health's policy guidelines.

118.22(7) *Leadership and administration.*

a. The program administrator shall complete and annually update Form 470-5679: IQ4K Quality Improvement Action Plan.

b. All staff shall receive a written evaluation at least once a year.

c. The program administrator shall have at least two years of full-time experience working in the field.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.23(237A) Criteria for IQ4K—Level 3 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school. To be rated at a Level 3, an eligible facility must satisfy all of the criteria in each of the seven designated categories listed in Levels 1, 2 and 3 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2 and 3.

118.23(1) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP, NSLP, or another department-approved CNP.

(2) If exempt from CACFP or NSLP, the program shall identify and implement two nutrition goals from the completed action plan in Level 1.

1. Programs providing adequate documentation they provide care for four hours a day or less are exempt from the CACFP or NSLP participation requirement.

2. Nonprofit programs shall qualify for an exemption from the CACFP or NSLP requirement if they provide adequate documentation that meets one of the following criteria:

- The percentage of children enrolled in the program qualifying for free or reduced meals is five percent or less.
- The program's licensed capacity is 30 or less.
- The program serves two or fewer meals or snacks per day.
- The program is open and operating three days a week or less.

3. For-profit programs shall qualify for an exemption from the CACFP or NSLP requirement if they are able to provide adequate documentation that the percentage of children enrolled in the program qualifying for free or reduced meals is 25 percent or less.

b. The program shall identify and implement two physical activity goals from the completed action plan in Level 1.

118.23(2) *Professional development.* All teaching staff shall complete ten annual training hours of professional development.

118.23(3) *Family and community partnerships.*

a. The program shall promote culturally sensitive practices and procedures.

b. The program shall complete three activities annually that promote partnerships.

118.23(4) *Teaching staff qualifications.* The average score for all lead teachers shall be three points or more on the IQ4K teaching staff qualifications worksheet.

118.23(5) *Teaching and learning.*

a. The program shall utilize an appropriate assessment tool throughout the year that aligns with the curriculum to gather information on each child's strengths, progress, and needs.

b. The program shall share community resources with families as needed based on the information gathered from the child's assessment.

c. The program shall develop and implement policies and procedures for inclusive practices for children with diverse needs, including those with identified disabilities, language barriers, identified behavioral needs, or specialized health needs.

118.23(6) *Environment.*

a. Thirty percent or more of lead teachers shall complete an appropriate ERS training, choosing between ITERS, ECERS or SACERS as applicable to ages served, and provide a certificate of completion.

b. The program shall participate in the completion of the health and safety checklist for early care and education programs.

c. The program shall develop and implement a policy regarding oral health aligned with CFOC.

118.23(7) *Leadership and administration.*

a. The program administrator shall complete one of the following:

(1) NAC or another DHS-approved credential.

(2) Thirty training hours (or more) in early childhood and ten training hours or more in leadership, administration, or management.

b. The program administrator shall have one of the following:

(1) Three years or more of full-time experience working in the field.

(2) One year or more full-time experience as a program administrator.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.24(237A) Criteria for IQ4K—Level 4 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school. To be rated at a Level 4, an eligible facility must satisfy all of the criteria in each of the seven designated categories listed in Levels 1, 2, 3 and 4 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2, 3 and 4.

118.24(1) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP, NSLP, or another department-approved CNP and shall identify and implement one nutrition goal from the completed action plan in Level 1.

(2) If exempt from CACFP or NSLP, the program shall identify and implement three nutrition goals from the completed action plan in Level 1.

b. The program shall identify and implement three physical activity goals from the completed action plan in Level 1.

118.24(2) *Professional development.*

a. All teaching staff shall complete 12 annual hours or more of professional development.

b. Sixty percent or more of all lead teachers shall complete the applicable EC-PBIS trainings based on age groups served.

(1) EC-PBIS Preschool modules 1 and 2.

(2) EC-PBIS Infant and Toddler modules 1 and 2.

118.24(3) *Family and community partnerships.* The program shall complete four activities annually that promote partnerships.

118.24(4) *Teaching staff qualifications.* The average score for all teaching staff shall be four points or more on the IQ4K teaching staff qualification worksheet.

118.24(5) *Teaching and learning.*

a. The teaching staff shall use assessment data and information gathered about children and families to make changes in their learning environment and activities.

b. The teaching staff shall participate in planning with families and outside experts, as needed, for children with diverse needs, including those with identified disabilities, language barriers, identified behavioral needs, and specialized health needs.

118.24(6) *Environment.*

a. Sixty percent or more of lead teachers shall complete an appropriate ERS training choosing between ITERS, ECERS or SACERS as applicable to ages served, and provide a certificate of completion.

b. One-third of all classrooms shall complete the ERS scoresheet with self-assessment and improvement plan using a minimum of one classroom per scale, if applicable.

c. The program shall score an average of 2.5 or higher on the health and safety checklist for early care and education.

118.24(7) *Leadership and administration.*

a. The program administrator shall meet Tier 1 or higher on the Iowa early care and education program administrator roles career pathway.

b. The program administrator shall have two or more years of full-time experience as a program administrator.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.25(237A) Criteria for IQ4K—Level 5 child care center, preschool, or program operating under the authority of an accredited school district or nonpublic school.

118.25(1) *Criteria for each category.* To be rated at Level 5, an eligible facility must satisfy all of the criteria in each of the seven designated categories listed in Levels 1, 2, 3, 4 and 5 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2, 3, 4 and 5. To be rated at a Level 5, an eligible facility must also meet the following criteria:

a. Minimum score. The facility must earn a minimum score of 5.0 in each assessed classroom on the appropriate ERS.

b. Approved assessor. An assessor approved by the department or department's designee must perform an environment rating assessment.

c. Number of classrooms assessed. At least one-third of the facility's classrooms must be assessed, including at least one classroom in each age group serviced by the facility.

d. Time frame for assessment. Programs eligible for ERS assessment must undergo their assessment within 90 days of department approval unless an extension is requested and approved by the department.

e. Assessments not done timely. Programs that do not undergo their assessment within 90 days of approval by the department or do not receive an approved extension from the department shall forfeit their opportunity for an assessment and will be awarded an IQ4K Level 4 rating with an effective date as outlined in rule 441—118.11(237A).

118.25(2) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP, NSLP, or another department-approved CNP and shall identify and implement two nutrition goals from the completed action plan in Level 1.

(2) If exempt from CACFP or NSLP, the program shall identify and implement four nutrition goals from the completed action plan in Level 1.

b. The program shall identify and implement four physical activity goals from the completed action plan in Level 1.

118.25(3) *Professional development.*

a. All teaching staff shall complete 12 annual hours or more of professional development.

b. Sixty percent or more of all lead teachers and the internal coach shall complete the EC-PBIS trainings as follows:

(1) EC-PBIS Preschool modules 3a and 3b.

(2) EC-PBIS Infant and Toddler modules 3.

(3) Prevent-Teach-Reinforce for Young Children (PTR-YC).

118.25(4) *Family and community partnerships.*

a. The program shall complete five activities annually that promote partnerships.

b. The program shall offer one additional conference with each family of preschool age children in care, per year, to discuss each child's progress, strengths, and needs in all developmental areas. Assessment information shall be shared with the family.

118.25(5) *Teaching staff qualifications.* The average score for all teaching staff shall be eight points or more on the IQ4K teaching staff qualification worksheet.

118.25(6) *Teaching and learning.*

a. The teaching staff shall work with families and other experts to implement instructional and environmental adaptations that support learning for each child, including those with diverse needs, identified disabilities, language barriers, identified behavioral health needs and specialized health needs.

b. The leadership team shall complete PW PBIS training. A leadership team must include an administrator, internal coach and teacher.

118.25(7) *Environment.*

a. Eighty percent or more of lead teachers shall complete an appropriate ERS training, choosing between ITERS, ECERS or SACERS, as applicable to ages served, and provide a certificate of completion.

b. One-third of all classrooms shall receive an overall score of five or higher on each classroom's ERS assessment when using a minimum of one classroom per scale, if applicable.

c. The program shall score an average of 2.75 or higher on the health and safety checklist for early care and education.

118.25(8) *Leadership and administration.*

a. The program administrator shall meet Tier 2 or higher on the Iowa early care and education program administrator roles career pathway.

b. The program administrator shall have three or more years of full-time experience as a program administrator.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.26(237A) Rating standards for school-aged only programs.

118.26(1) To participate in IQ4K QRIS, a school-aged only program shall certify that its facility meets the applicable criteria as defined in rules 441—118.27(237A) through 441—118.31(237A).

118.26(2) The following program requirements apply:

a. Eligible applicants providing adequate documentation of current verification or certification in one of the preapproved specialized track areas shall only be required to satisfy the criteria outlined in the application consistent with their specialized track.

b. Programs with more than one classroom shall not be eligible to apply using a specialized track application unless over 50 percent of their eligible classrooms meet the specialized track requirements.

c. Eligible applicants shall be able to earn credit for participation in more than one of the specialized track areas.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.27(237A) Criteria for IQ4K—Level 1 school-aged only programs. To be rated at a Level 1, an eligible facility must satisfy all of the criteria in each of the six designated categories listed in Level 1 or complete all of the criteria designated in its respective specialized tracks.

118.27(1) *Nutrition and physical activity.*

a. The program administrator and any staff members who prepare meals shall complete one of the department-approved food safety trainings.

b. A self-assessment and action plan in the area of nutrition shall be completed for an eligible facility.

c. A self-assessment and action plan in the area of physical activity shall be completed for an eligible facility.

118.27(2) *Professional development.*

a. All staff shall complete a professional development plan within six months of each person's hiring date and update the plan annually.

b. All staff shall complete one of the department-identified new staff orientation courses and must provide a valid certificate of completion. Newly hired staff shall have nine months from date of hire to complete this requirement.

118.27(3) *Family and community partnerships.*

a. The program shall provide an orientation for new families.

b. The program shall complete one annual activity that promotes partnerships.

118.27(4) *Teaching and learning.*

a. The program shall provide assistance or access to tutors to support homework or students' learning needs.

b. The program shall develop and implement a comprehensive discipline and behavior policy that promotes positive relationships.

c. The program shall develop and implement a comprehensive and age-appropriate schedule of activities.

118.27(5) *Environment.*

a. The program shall develop and implement, as applicable to ages served, the following policies aligned to CFOC:

(1) Supervision.

(2) Bullying prevention.

(3) Playground equipment stability and fall surfacing and inspection.

(4) Missing child.

(5) Strangulation prevention.

(6) Sign in and out tracking system for children and visitors.

(7) Technology.

b. The program shall submit one of the following annually:

(1) Form 470-5676: IQ4K Interaction and Relationship Self-Assessment, which shall be completed by teaching staff.

(2) CLASS assessment for the age level being served and completed for each classroom by a trained observer.

118.27(6) *Leadership and administration.*

a. All staff shall complete Form 470-5680: IQ4K Staff Self-Assessment annually.

b. The program administrator shall complete Form 470-5677: IQ4K Program Assessment annually.

c. Meetings for all staff shall be conducted two or more times per year.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.28(237A) Criteria for IQ4K—Level 2 school-aged only programs. To be rated at a Level 2, an eligible facility must satisfy all of the criteria in each of the six designated categories listed in Levels 1 and 2 or complete all of the criteria designated in its respective specialized tracks for Levels 1 and 2.

118.28(1) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP, NSLP or another department-approved CNP.

(2) The program shall complete all of the following as applicable to ages served:

1. Program staff planning the meals and their supervisor shall complete the CACFP Steps to Success module 2 lessons as identified by the department that cover the CACFP meal pattern.

2. All lead staff and their supervisors responsible for mealtime supervision shall complete the video "CACFP School-Age Program Staff Training."

b. The program shall identify and implement one physical activity goal from the completed action plan in Level 1.

118.28(2) *Professional development.*

a. All staff who administer medication shall complete the Medication Administration Skills Competency Course or other training as approved by the department and hold a valid certification of completion.

b. All staff who administer medication shall also successfully complete a competency skills evaluation assessment checklist or department-approved equivalent and hold a valid certification of completion. There shall be one person who meets these criteria present on site in the program at all times.

c. All staff shall complete ten annual training hours of professional development.

118.28(3) *Family and community partnerships.*

a. The program shall offer one conference with each family per year to discuss each child's progress, strengths, and needs in all developmental areas.

b. The program shall complete two activities annually that promote partnerships.

118.28(4) *Teaching and learning.*

a. The program shall develop and implement a curriculum that includes all of the following opportunities each day:

(1) Active physical activity.

(2) Creative expression.

(3) Cooperative games.

(4) Free choice with a variety of materials.

(5) Academic support.

b. The program shall develop and implement a policy that eliminates or severely limits expulsion, suspension, and punitive or other exclusionary discipline.

118.28(5) *Environment.*

a. The program administrator or assistant administrator shall complete the SACERS training and provide a certificate of completion.

b. The program shall provide an environment supportive to and encouraging of culture, age, race, ability, special needs, and gender diversity.

c. The program shall develop and implement a tobacco-free and nicotine-free policy aligned to the Iowa department of public health's policy guidelines.

118.28(6) *Leadership and administration.*

a. The program administrator shall complete and annually update Form 470-5679: IQ4K Quality Improvement Action Plan.

b. All staff shall receive a written evaluation at least once a year.

c. The program administrator shall have at least two or more years of full-time experience working in the field.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.29(237A) Criteria for IQ4K—Level 3 school-aged only programs. To be rated at a Level 3, an eligible facility must satisfy all of the criteria in each of the six designated categories listed in Levels 1, 2 and 3 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2 and 3.

118.29(1) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP, NSLP or another department-approved CNP.

(2) If exempt from CACFP or NSLP, the program shall identify and implement two nutrition goals from the completed action plan in Level 1.

1. Programs providing adequate documentation that they provide care for four hours a day or less are exempt from the CACFP or NSLP participation requirement.

2. Nonprofit programs shall qualify for an exemption from the CACFP or NSLP requirement if they provide adequate documentation that meets one of the following criteria:

- The percentage of children enrolled in the program qualifying for free or reduced meals is five percent or less.
- The program's licensed capacity is 30 children or fewer.
- The program serves two or fewer meals or snacks per day.
- The program is open and operating three days a week or less.

3. For-profit programs shall qualify for an exemption from the CACFP or NSLP requirement if they are able to provide adequate documentation that the percentage of children enrolled in the program qualifying for free or reduced meals is 25 percent or less.

b. The program shall identify and implement two physical activity goals from the completed action plan in Level 1.

118.29(2) *Professional development.* All staff shall complete ten or more annual training hours of professional development.

118.29(3) *Family and community partnerships.*

a. The program shall promote culturally sensitive practices and procedures.

b. The program shall complete three activities annually that promote partnerships.

118.29(4) *Teaching and learning.*

a. Program staff shall utilize an appropriate tool throughout the year to gather information about children's strengths, progress, and needs.

b. The program shall share community resources with families as needed based on the information gathered.

c. The program shall develop and implement policies and procedures for inclusive practices for children with diverse needs, including those with identified disabilities, language barriers, identified behavioral needs, or specialized health needs.

118.29(5) *Environment.*

a. The on-site supervisor shall complete the SACERS training series and provide a certificate of completion.

b. The program shall participate in the completion of the health and safety checklist for early care and education programs.

118.29(6) *Leadership and administration.*

a. The program administrator shall complete:

(1) NAC or another department-approved credential, or

(2) Thirty training hours or more in a related field and ten training hours or more in leadership.

b. The program administrator shall have three years or more of full-time experience working in the field or one year or more of full-time experience as a program administrator.

c. The on-site supervisor shall have 30 training hours or more in a related field and two years or more of full-time experience working in the field.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.30(237A) Criteria for IQ4K—Level 4 school-aged only programs. To be rated at a Level 4, an eligible facility must satisfy all of the criteria in each of the six designated categories listed in Levels 1, 2, 3 and 4 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2, 3 and 4.

118.30(1) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP, NSLP or another department-approved CNP and shall identify and implement one nutrition goal from the completed action plan in Level 1.

(2) If exempt from CACFP or NSLP, the program shall identify and implement three nutrition goals from the completed action plan in Level 1.

b. The program shall identify and implement three physical activity goals from the completed action plan in Level 1.

118.30(2) *Professional development.*

a. All staff shall complete 12 or more annual training hours of professional development.

b. Thirty percent or more of all staff shall complete six or more hours of department or IQ4K-approved training in the area of SEBMH.

118.30(3) *Family and community partnerships.* The program shall complete four activities annually that promote partnerships.

118.30(4) *Teaching and learning.*

a. Staff shall use information gathered about children and families to make changes in their learning environment and activities.

b. Staff shall participate in planning with families and outside experts as needed for children with diverse needs, including those with identified disabilities, language barriers, identified behavioral needs, or specialized health needs.

118.30(5) *Environment.*

a. One staff member or more shall complete the SACERS training series and provide a certificate of completion.

b. One-third of classrooms shall complete the SACERS scoresheet with self-assessment and an improvement plan with a minimum of one classroom per scale if applicable.

c. The program shall score an average of 2.5 or higher on the health and safety checklist for early care and education.

118.30(6) *Leadership and administration.*

a. The program administrator shall have 120 training hours or more in a related field and 10 training hours or more in leadership, administration or management.

b. The program administrator shall have two years or more of full-time experience as a program administrator.

c. The on-site supervisor shall have 90 training hours or more in a related field and one year or more of full-time experience as an on-site supervisor.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.31(237A) Criteria for IQ4K—Level 5 school-aged only programs.

118.31(1) *Criteria for each category.* To be rated at a Level 5, an eligible facility must satisfy all of the criteria in each of the six designated categories listed in Levels 1, 2, 3, 4 and 5 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2, 3, 4 and 5. To be rated at a Level 5, an eligible facility must also meet the following criteria:

a. Minimum score. The facility must earn a minimum score of 5.0 in each assessed classroom on the SACERS assessment.

b. Approved assessor. An assessor approved by the department or department's designee must perform the ERS assessment.

c. Number of classrooms assessed. At least one-third of the facility's classrooms must be assessed, including at least one classroom in each age group served by the facility.

d. Time frame for assessment. Programs eligible for an ERS assessment must undergo their assessment within 90 days of department approval unless an extension is requested and approved by the department.

e. Assessments not done timely. Programs that do not undergo their assessment within 90 days of approval by the department or do not receive an approved extension from the department shall forfeit their opportunity for an assessment and will be awarded an IQ4K Level 4 rating with an effective date as outlined in rule 441—118.11(237A).

118.31(2) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP, NSLP or another department-approved CNP and shall identify and implement two nutrition goals from the completed action plan in Level 1.

(2) If exempt from CACFP or NSLP, the program shall identify and implement four nutrition goals from the completed action plan in Level 1.

b. The program shall identify and implement four physical activity goals from the completed action plan in Level 1.

118.31(3) *Professional development.*

a. All staff shall complete 12 or more annual training hours of professional development.

b. Sixty percent or more of all staff shall complete six or more hours of department-approved or IQ4K-approved training in the area of SEBMH.

118.31(4) *Family and community partnerships.* The program shall complete five activities annually that promote partnerships.

118.31(5) *Teaching and learning.* The teaching staff shall work with families and other experts to implement instructional and environmental adaptations that support the learning for each child including those with diverse needs, language barriers, identified behavioral needs, or specialized health needs.

118.31(6) *Environment.*

a. Eighty percent or more of lead teachers shall complete the SACERS training series and provide a certificate of completion.

b. One-third of classrooms shall receive an overall score of 5.0 or higher on the SACERS assessment with a minimum of one classroom per scale if applicable.

c. The program shall score an average of 2.75 or higher on the health and safety checklist for early care and education.

118.31(7) *Leadership and administration.*

a. The program administrator shall have 9 or more credit hours in a related field and 12 or more training hours in leadership, administration or management.

b. The program administrator shall have three or more years of full-time experience as a program administrator.

c. The on-site supervisor shall have six or more credit hours in a related field and two or more years of full-time experience as an on-site supervisor.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.32(237A) Rating standards for registered child development homes. To participate in IQ4K QRIS, a registered child development home shall certify that it meets the applicable criteria as defined in rules 441—118.33(237A) through 441—118.37(237A). The following program requirements apply:

1. For Category C homes operating with an approved coprovider, both providers must satisfy the applicable criteria where designated.

2. Eligible applicants providing documentation of current verification or certification in one of the preapproved specialized track areas shall only be required to satisfy the criteria outlined in the application consistent with their specialized track.

3. Eligible applicants shall be able to earn credit for participation in more than one of the specialized track areas.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.33(237A) Criteria for IQ4K—Level 1 rating standards for registered child development homes. To be rated at Level 1, an eligible registered child development home must satisfy all of the criteria in each of the six designated categories listed in Level 1 or complete all of the criteria designated in its respective specialized tracks for Levels 1 and 2.

118.33(1) *Nutrition and physical activity.*

a. The provider and coprovider, where applicable, shall complete one of the department-approved food safety trainings.

b. The program shall complete a self-assessment and create an action plan in the area of nutrition.

c. The program shall complete a self-assessment and create an action plan in the area of physical activity.

118.33(2) *Professional development.* The provider and coprovider, where applicable, shall complete a professional plan annually.

118.33(3) *Family and community partnerships.*

a. The program shall provide an orientation for new families.

b. The program shall complete one annual activity that promotes partnerships.

118.33(4) *Provider qualifications.* The provider and coprovider, where applicable, shall have one year or more of full-time child care experience.

118.33(5) *Teaching and learning.*

a. The provider and coprovider, where applicable, shall complete two hours of training on the Iowa early learning standards.

b. The program shall develop and implement a comprehensive discipline and behavior policy that promotes positive relationships.

118.33(6) *Environment.*

a. The program shall develop and implement, as applicable to ages served, the following policies aligned to CFOC:

(1) Supervision.

(2) Safe sleep.

(3) Missing child.

(4) Strangulation prevention.

(5) Sign in and out tracking system for children and visitors.

b. The provider and coprovider, where applicable, shall complete Form 470-5676: IQ4K Interaction and Relationship Self-Assessment.

c. The program shall annually complete Form 470-5678: IQ4K Program Assessment.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.34(237A) Criteria for IQ4K—Level 2 rating standards for registered child development homes. To be rated at a Level 2, an eligible registered child development home must satisfy all of the criteria in each of the six designated categories listed in Levels 1 and 2 or complete all of the criteria designated in its respective specialized tracks.

118.34(1) *Nutrition and physical activity.*

a. The program shall choose one of the following:

(1) The program shall actively participate in CACFP.

(2) The provider and coprovider, where applicable, shall complete all of the following as applicable to ages served:

1. Iowa CACFP Steps to Success module 2 lessons as identified by the department that cover the CACFP Meal Pattern.

2. Iowa CACFP Infant Training—Steps to Success module 15, parts one and two.

3. Iowa CACFP Wellness module—Meaningful Mealtimes.

b. The program shall identify and implement one physical activity goal from the completed action plan in Level 1.

118.34(2) *Professional development.* There shall be one person who meets the following criteria present on site in the program at all times.

a. The provider and coprovider, where applicable, shall complete ChildNet Training.

b. The provider and coprovider, where applicable, shall complete 15 hours or more of annual training hours of professional development.

c. The provider shall complete the medication administration skills competency course or other department-approved training and hold a valid certification of completion.

d. The provider shall also successfully complete a competency skills evaluation assessment checklist or department-approved equivalent and hold a valid certification of completion.

118.34(3) *Family and community partnerships.*

a. The program shall offer one conference with each family annually to discuss each child's progress, strengths and needs in all developmental areas. Programs shall share child assessment information with the child's family.

b. The program shall complete two activities annually that promote partnerships.

118.34(4) *Provider qualifications.* The provider and coprovider, where applicable, shall meet one of the following:

a. Two years or more of full-time experience in child care.

b. Six college credit hours or more in education specific to the age group for whom care is provided.

118.34(5) *Teaching and learning.*

a. The program shall develop and implement a daily schedule with predictable routines that are developmentally appropriate for all ages served.

b. The program shall develop and implement a policy that eliminates or severely limits expulsion, suspension, and punitive or other exclusionary discipline.

c. The program shall develop and implement policies regarding the use of an approved developmental screening tool for all children in care within 60 days of enrollment and at least annually to identify children who may need additional evaluation and intervention strategies.

118.34(6) *Environment.*

a. The program shall provide an environment supportive to, and encouraging of, culture, age, race, ability, special needs, and gender diversity.

b. The program shall develop and implement a policy regarding playground equipment stability and fall surfacing and inspection which are aligned with CFOC.

c. The program shall develop and implement a tobacco-free and nicotine-free policy.

d. The program shall annually complete and update Form 470-5679: IQ4K Quality Improvement Action Plan.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.35(237A) Criteria for IQ4K—Level 3 rating standards for registered child development homes. To be rated at a Level 3, an eligible registered child development home must satisfy all of the criteria in each of the six designated categories listed in Levels 1, 2 and 3 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2 and 3.

118.35(1) *Nutrition and physical activity.*

a. The program shall actively participate in CACFP.

b. The program shall identify and implement two physical activity goals from the completed action plan in Level 1.

118.35(2) *Professional development.*

a. The provider and coprovider, where applicable, shall complete ChildNet Certification.

b. The provider and coprovider, where applicable, shall choose one of the following trainings to complete their initial IQ4K rating:

(1) Complete one module of the Program for Infant and Toddler Care.

(2) Complete module 1 of the EC-PBIS for Family Child Care and complete the following implementation guide checklists and review with coach:

1. Relationships.
2. Environments.
3. Expectations, Activities and Feedback.

(3) Complete School Age Matters training.

c. The provider and coprovider, where applicable, shall choose one of the other trainings listed above for their subsequent IQ4K ratings until all of the trainings applicable per ages served have been completed.

d. Once the provider and coprovider, as applicable, have completed all of the age applicable trainings, the provider and coprovider shall complete 18 annual hours of approved professional development training on all subsequent IQ4K applications.

118.35(3) *Family and community partnerships.*

a. The program shall promote culturally sensitive practices and procedures.

b. The program shall complete three activities annually that promote partnerships.

118.35(4) *Provider qualifications.* The provider and coprovider, where applicable, shall meet one of the following:

a. Three years or more of child care experience.

b. Nine or more college credit hours in education, specific to the age group for whom care is provided.

118.35(5) *Teaching and learning.*

a. The program shall utilize an appropriate assessment tool throughout the year that aligns with the curriculum to gather information on each child's strengths, progress, and needs.

b. The program shall share community resources with families as needed, based on the information gathered from the child's assessment.

c. The program shall develop and implement policies and procedures for inclusive practices for children with diverse needs, including those with identified disabilities, language barriers, identified behavioral needs, and specialized health needs.

118.35(6) *Environment.*

a. The provider shall complete the FCCERS training and provide a certificate of completion.

b. A self-assessment and action plan in the area of nutrition shall be completed for an eligible facility.

c. A self-assessment and action plan in the area of physical activity shall be completed for an eligible facility.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.36(237A) Criteria for IQ4K—Level 4 rating standards for registered child development homes. To be rated at Level 4, an eligible registered child development home must satisfy all of the criteria in each of the six designated categories listed in Levels 1, 2, 3 and 4 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2, 3 and 4.

118.36(1) *Nutrition and physical activity.*

a. The program shall actively participate in CACFP.

b. The program shall implement one nutrition goal from the completed action plan in Level 1.

c. The program shall identify and implement three physical activity goals from the completed action plan in Level 1.

118.36(2) *Professional development.*

a. The provider and coprovider, where applicable, shall choose one of the following trainings to complete for their initial IQ4K rating:

(1) Complete two additional modules of the Program for Infant and Toddler Care.

(2) Complete module 2 of the EC-PBIS for Family Child Care and complete the following implementation guide checklists and review with coach:

1. Emotions and Emotional Regulation.
2. Friendships and Problem Solving.

b. The provider and coprovider, where applicable, shall chose one of the other trainings listed above for their subsequent IQ4K ratings until all of the trainings applicable per ages served have been completed.

c. Once the provider and coprovider, as applicable, have completed all of the age applicable trainings, the provider and coprovider shall complete 20 annual hours of approved professional development training on all subsequent IQ4K applications.

118.36(3) *Family and community partnerships.* The program shall complete four activities annually that promote partnerships.

118.36(4) *Provider qualifications.* The provider and coprovider, where applicable, shall meet one of the following:

a. The provider shall meet Tier 2 or higher on the Iowa early care and education teaching roles career pathway.

b. The provider shall have three or more years of full-time child care experience.

118.36(5) *Teaching and learning.*

a. The program shall use information gathered about children and families to make changes in their learning environment and activities.

b. The program shall participate in planning with families and other experts, as needed, for children with diverse needs, including those with identified disabilities, language barriers, identified behavioral health needs and specialized health needs.

118.36(6) *Environment.*

a. The program shall complete the FCCERS scoresheet with self-assessment and improvement plan.

b. The program shall score an average of 2.5 or higher on the health and safety checklist for early care and education programs.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.37(237A) Criteria for IQ4K—Level 5 rating standards for registered child development homes.

118.37(1) *Criteria for each category.* To be rated at a Level 5, an eligible registered child development home must satisfy all of the criteria in each of the six designated categories listed in Levels 1, 2, 3, 4 and 5 or complete all of the criteria designated in its respective specialized tracks for Levels 1, 2, 3, 4 and 5. To be rated at a Level 5 the following criteria must also be met:

a. Minimum score. The program must earn a minimum score of 5.0 on the FCCERS assessment.

b. Approved assessor. An assessor approved by the department or department's designee must perform the ERS assessment.

c. Time frame for assessment. Programs eligible for an ERS assessment must undergo their assessment within 90 days of department approval unless an extension is requested and approved by the department.

d. Assessments not done timely. Programs that do not undergo their assessment within 90 days of approval by the department or that do not receive an approved extension from the department shall forfeit their opportunity for an assessment and will be awarded an IQ4K Level 4 rating with an effective date as outlined in rule 441—118.11(237A).

118.37(2) *Nutrition and physical activity.*

a. The program shall actively participate in CACFP.

b. The program shall identify and implement two nutrition goals from the completed action plan in Level 1.

c. The program shall identify and implement four physical activity goals from the completed action plan in Level 1.

118.37(3) *Professional development.*

a. The provider shall choose one of the following trainings to complete the initial IQ4K rating:

(1) Complete two additional modules of the Program for Infant and Toddler Care.

(2) Complete EC-PBIS for Family Child Care Benchmarks of Quality and action plan for continued implementation and growth with coach. The EC-PBIS for Family Child Care must be completed.

b. The provider shall then choose one of the other trainings listed above for the subsequent IQ4K ratings until all of the trainings applicable per ages served have been completed.

c. Once the provider has completed all of the age-applicable trainings, the provider shall complete 22 annual hours of approved professional development training on all subsequent IQ4K applications.

118.37(4) *Family and community partnerships.* The program shall complete five activities annually that promote partnerships.

118.37(5) *Provider qualifications.*

a. The provider shall meet Tier 2 or higher on the Iowa early care and education teaching roles career pathway.

b. The provider shall have four or more years of full-time child care experience.

118.37(6) *Teaching and learning.* The program shall work with families and other experts to implement instructional and environmental adaptations that support the learning for each child, including those with diverse needs, identified disabilities, language barriers, identified behavioral health needs and specialized health needs.

118.37(7) *Environment.*

a. The program shall achieve a score of 5.0 or higher on the FCCERS assessment.

b. The program shall score an average of 2.75 or higher on the health and safety checklist for early care and education programs.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.38(237A) Award of quality rating.

118.38(1) The facility shall display Form 470-5681: IQ4K QRIS rating certificate in a conspicuous place.

118.38(2) Achievement bonuses may be awarded as funds are available.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

441—118.39(237A) Adverse actions.

118.39(1) An eligible applicant shall be notified of the right to appeal the rating decision in accordance with 441—Chapter 7.

118.39(2) A participant's quality rating shall be revoked if the facility no longer meets the definition of eligible applicant.

[**ARC 6277C**, IAB 4/6/22, effective 6/1/22]

These rules are intended to implement Iowa Code section 237A.30.

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[Filed ARC 6277C (Notice ARC 6161C, IAB 1/26/22), IAB 4/6/22, effective 6/1/22]

CHAPTER 119
RECORD CHECK EVALUATIONS FOR CERTAIN EMPLOYERS AND EDUCATIONAL TRAINING PROGRAMS

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

441—119.1(135B,135C) Definitions.

"Deferred judgment" means the same as defined in Iowa Code section 907.1 and is considered an admission of committing an act. Under this chapter, the admission of committing an act must be considered a conviction for purposes of public protection.

"Requesting entity" means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can be employed by the entity or participate in a training or education program and includes the following:

1. Health care facilities as defined in Iowa Code section 135C.1.
2. Programs in which the provider is regulated by the state or receives any state or federal funding and the employee being evaluated provides direct services to consumers, including but not limited to programs that employ homemakers or home health aides, programs that provide adult day services, hospices, federal home- and community-based services waiver providers, elder group homes, and assisted living programs.
3. Substance abuse programs for juveniles as described in Iowa Code section 125.14A.
4. Hospitals as defined in Iowa Code section 135B.1.
5. Psychiatric medical institutions for children as defined in Iowa Code section 135H.1.
6. The department as described in Iowa Code sections 217.44 and 217.45.
7. Department institutions as described in Iowa Code section 218.13.
8. Child foster care facilities as described in Iowa Code section 237.1.
9. Medicaid home- and community-based services waiver providers as described in Iowa Code section 249A.29.
10. Certified nurse aide training programs as described in Iowa Code section 135C.33(9).
11. Nursing education programs as described in Iowa Code chapter 152.

"Start employment or attend the training program" means to begin to receive a salary or take classes.

"Training" means certified nurse aide training programs as described in Iowa Code section 135C.33(9) or nursing education programs as described in Iowa Code chapter 152.

[**ARC 0349D**, IAB 6/10/26, effective 8/1/26]

441—119.2(135B,135C) When record check evaluations are requested.

119.2(1) *Record check evaluations on prospective employees and students.* A requesting entity shall request a record check evaluation prior to employment or enrollment of a person whose background check indicates a criminal or dependent adult abuse or child abuse record. Any deferred judgments will be considered in criminal background checks. Criminal, child abuse and dependent adult abuse background checks are required on all prospective employees or students, including employees or students who have terminated employment or participation in a training program for any reason or any length of time and wish to return to the same employment or training program, unless an exemption is provided in these rules.

a. A hospital or licensee of a health care facility may employ a person for up to 60 calendar days pending completion of the evaluation if all the following criteria are met:

(1) The employment does not involve operation of a motor vehicle; and

(2) The person to be employed has been convicted of a simple misdemeanor offense under Iowa Code section 123.47 or chapter 321 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2(1); and

(3) The person to be employed does not have a record of founded child or dependent adult abuse; and

(4) The hospital or licensee has requested an evaluation.

b. A training program in a facility licensed under Iowa Code chapter 135C may allow a student who is applying for, enrolled in, or returning to a certified nurse aide training program to participate in the clinical education component of the training program for up to 60 calendar days pending completion of the evaluation if all of the following criteria are met:

(1) The student's clinical education component of the training program involves children or dependent adults; and

(2) The program does not involve operation of a motor vehicle; and

(3) The student has been convicted of a simple misdemeanor offense under Iowa Code section 123.47 or chapter 321 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2(1); and

(4) The student does not have a record of founded child or dependent adult abuse; and

(5) The training program has requested an evaluation.

119.2(2) *Record check evaluations on current employees and students.* A requesting entity shall request a record check evaluation on current employees and students when a current employee or student background check indicates a criminal conviction other than an Iowa Code chapter 321 simple misdemeanor or equivalent simple misdemeanor offense from another jurisdiction or a dependent adult or child abuse record and the requesting entity intends to continue to employ the employee or to continue the student's enrollment in a training program. The requesting entity shall request a current criminal or dependent adult or child abuse record check when the entity receives credible information as determined by the entity that a current employee or student has a criminal or dependent adult or child abuse record that has not been previously considered by the requesting entity.

119.2(3) *Transfer of employee between facilities.* If a person owns or operates more than one facility, and an employee of one of the facilities is transferred to another facility without a lapse in employment, the facility is not required to request additional criminal or abuse record checks of the employee or obtain a new record check evaluation.

119.2(4) *Exceptions to record check evaluation requirements for employment under Iowa Code chapter 135B or 135C or participation in a training program in facilities licensed under Iowa Code chapter 135C.* If an evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment, the person who is or was employed by a hospital licensed under Iowa Code chapter 135B and is hired by another hospital or the person who is or was employed by a facility licensed under Iowa Code section 135C.33 and is hired by another facility licensed under Iowa Code section 135C.33 may commence employment without further action by the department subject to the following conditions:

a. The record check performed by the subsequent employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

b. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

c. Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

d. The person subject to the record checks has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a new record check evaluation shall be performed.

e. Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

f. The subsequent employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

119.2(5) *Exceptions to record check evaluation requirements for new employees under Iowa Code chapter 135B or 135C or participants in a training program in facilities licensed under Iowa Code chapter 135C.* If the person approved for employment or participation does not start employment or attend the training program within 30 days from the notice of decision approving the person, the requesting entity must perform a new record check.

a. If the evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment or participation

in a training program, the person being considered for employment may commence employment without further action by the department subject to the following conditions:

(1) The record check performed by the employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

(2) The position with the employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

(3) Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

(4) The employer or person subject to the record checks has maintained a copy of the previous evaluation. If a physical copy of the previous evaluation is not maintained, a new record check evaluation shall be requested.

(5) Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

(6) The employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

b. If the record check indicates that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation, a new record check evaluation shall be performed.

c. Record check evaluations completed in accordance with paragraph 119.4(3)*"c"* are valid for 30 days from the date the notice of decision is issued. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply.

[**ARC 0349D**, IAB 6/10/26, effective 8/1/26]

441—119.3(135C) Request for evaluation.

119.3(1) *Required documentation.* The requesting entity and the prospective employee or student shall complete and submit a Record Check Evaluation Form (470-2310) to the department by regular mail, email, or fax to request an evaluation. The department will not process evaluations that are not signed by the prospective employee or student. The position sought or held must be clearly written on the first page of the record check evaluation form. The form shall be accompanied by the following documents:

a. A copy of the documentation of the person's status on the division of criminal investigation (DCI) criminal history database generated within 30 days of the date on which the request for evaluation is submitted to the department.

b. A copy of the Iowa criminal history data, if there is a history, as provided to the requesting entity by DCI.

c. A copy of the documentation of the person's status on the dependent adult abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

d. A copy of the documentation of the person's status on the child abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

119.3(2) *Additional documentation.*

a. The requesting entity may provide or the department may request from the prospective employee or student or from the requesting entity information to assist in performance of the evaluation that includes but is not limited to the following:

(1) Documentation of criminal justice proceedings.

(2) Documentation of rehabilitation.

(3) Written employment references or applications.

(4) Documentation of substance abuse education or treatment.

(5) Criminal history records, child abuse information, and dependent adult abuse information from other states.

(6) Documentation of the applicant's prior residences.

b. Any person or agency that might have pertinent information regarding the criminal or abuse history and rehabilitation of a prospective employee or student may be contacted.

[**ARC 0349D**, IAB 6/10/26, effective 8/1/26; Editorial change: IAC Supplement 9/2/26]

441—119.4(135B,135C) Completion of evaluation.

119.4(1) *Considerations.* The department will consider the following when conducting a record check evaluation:

a. The nature and seriousness of the crime or founded child or dependent adult abuse in relation to the position sought or held.

b. The time elapsed since the commission of the crime or founded child or dependent adult abuse.

c. The circumstances under which the crime or founded child or dependent adult abuse was committed.

d. The degree of rehabilitation.

e. The likelihood that the person will commit a crime or founded child or dependent adult abuse again.

f. The number of crimes or instances of founded child or dependent adult abuse committed by the person involved.

119.4(2) *Evaluation conclusions.*

a. The department may determine the following:

(1) The person may be employed by the entity or enroll in the training program with no restrictions.

(2) The person may be employed by the entity or enroll in the training program with restrictions.

(3) The person may be employed by the entity or enroll in the training program with restrictions specific to a position within the program.

(4) The person may not be employed by the entity or enroll in the training program.

b. Restrictions on a person's employment or enrollment status will be based upon what is necessary for the protection of the person or persons receiving care.

c. Medicaid waiver attendant care evaluations will determine that either the person may work or the person may not work pursuant to Medicaid law.

119.4(3) *Notice of decision.* The department will issue a notice of decision in writing to the requesting entity. The requesting entity is responsible for providing a copy of the notice to the prospective employee or student.

a. The notice will be valid only for employment with the employer or enrollment in a training or education program that requested the record check evaluation.

b. The notice shall not be valid for employment with any other prospective employer or enrollment in another training program.

c. Record check evaluations are valid for 30 days from the date the notice of decision is issued pursuant to 441—Chapter 16. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply.

d. The notice of decision shall contain the notice of right to appeal pursuant to 441—Chapter 7.

[**ARC 0349D**, IAB 6/10/26, effective 8/1/26]

441—119.5(135B,135C) Appeal rights. Any person or the person's attorney may file a written statement with the department requesting an appeal of the record check evaluation decision within 30 days of the date of the notice of the results of the record check evaluation in accordance with 441—Chapter 7.

[**ARC 0349D**, IAB 6/10/26, effective 8/1/26]

These rules are intended to implement Iowa Code section 135C.33.

[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
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[Editorial change: IAC Supplement 9/2/26]

CHAPTER 120
CHILD CARE HOMES

Rescinded **ARC 0692D**, IAB 10/28/26, effective 1/1/27

CHAPTER 121
EARLY CHILDHOOD IOWA INITIATIVE
[Prior to 6/14/23, see Early Childhood Iowa State Board[249] Ch 1]

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

441—121.1(256I) Definitions. For the purpose of these rules, the following definitions apply:

"Community partners" means individuals, early childhood service providers, and staff of other programs or agencies who communicate, coordinate and collaborate with an area board.

"Designation" means the status awarded by the state board to an early childhood Iowa area meeting the criteria established by the state board.

"Early childhood Iowa area" or *"area"* means the same as defined in Iowa Code section 256I.1.

"Early childhood Iowa area board" or *"area board"* means the same as defined in Iowa Code section 256I.1.

"Early childhood Iowa fund" means a fund created in the state treasury from which moneys are distributed to early childhood Iowa areas for the purpose of supporting children and their families.

"Early childhood Iowa office" means a state unit within the department to coordinate the early childhood Iowa initiative.

"Early childhood Iowa state board" or *"state board"* means the state of Iowa's early childhood Iowa board as appointed by the governor that meets the membership criteria of citizens and state agency directors as voting members and legislators as nonvoting members.

"Evidence-based" means that a program has completed a randomized control trial conducted by an independent researcher and has demonstrated positive results for children and families. "Evidence-based" may also include research conducted by the program that has been published in a peer-reviewed journal that also demonstrates positive results for children and families. To be evidence-based, the program must include stringent standards for program replication including standards for implementation and monitoring to ensure that the program is being operated with fidelity to the original model.

"Indicator" means a measure that indirectly quantifies the achievement of a result.

"Result" means the effect desired for Iowans.

"State agency" means a department of the executive branch including but not limited to the departments of economic development, education, health and human services, and workforce development.

[**ARC 9150C**, IAB 4/30/25, effective 7/1/25]

441—121.2(256I) Early childhood Iowa state board responsibility.

121.2(1) The state board will provide leadership and coordination for the development of Iowa's early care, health and education system in cooperation with area boards, community partners and other state agencies.

121.2(2) The state board will:

a. Develop and implement a process for designating area boards. The state board will review the process at the close of each designation cycle.

b. Adopt state-level indicators with input from area boards. The state board will report on indicators each fiscal year and compare the data against baseline data and data from prior fiscal years as available. Indicators will measure all result areas of the early care, health and education system.

c. Adopt minimum standards to promote equal access to services subject to the authority of the area boards.

d. Adopt guidelines and standards for services provided under a school ready children grant. All guidelines and standards will be found in the online toolkit available on department's official website.

e. Further the development of an early childhood integrated data system across state agencies and other partners.

f. Develop guidance to identify and improve the quality of services in early care, health and education programs, including evidence-based practices.

g. Promote other measures to advance the initiative.

[**ARC 9150C**, IAB 4/30/25, effective 7/1/25]

441—121.3(256I) Early childhood Iowa coordination staff. In consultation with the state board, the department will provide fiscal oversight of the early childhood Iowa initiative. The fiscal oversight measures are defined in 441—Chapter 122.
[**ARC 9150C**, IAB 4/30/25, effective 7/1/25]

441—121.4(256I) Early childhood Iowa areas.

121.4(1) The state board will approve early childhood Iowa area boundaries and the creation of area boards. Minimum criteria for areas and approval of area boards are set forth in Iowa Code section 256I.6.

121.4(2) The state board may waive any of the minimum criteria referenced in Iowa Code section 256I.6, if it is determined that exceptional circumstances exist. The state board further defines exceptional circumstances to include when the proposed change of boundaries creates hardship that reduces performance or quality of services within the area. The area board must provide compelling documentation of the hardship and clearly document the impact to performance or quality of services or both.
[**ARC 9150C**, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement Iowa Code sections 256I.1 through 256I.11.

[Filed ARC 9346B (Notice ARC 9137B, IAB 10/6/10), IAB 1/26/11, effective 3/2/11]
[Filed ARC 0179C (Notice ARC 0058C, IAB 4/4/12), IAB 6/27/12, effective 8/1/12]
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[Filed ARC 9150C (Notice ARC 8529C, IAB 12/11/24), IAB 4/30/25, effective 7/1/25]

CHAPTER 122
FISCAL OVERSIGHT OF THE EARLY CHILDHOOD IOWA INITIATIVE
[Prior to 6/14/23, see Management Department[541] Ch 9]

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

441—122.1(256I) Definitions. For the purpose of these rules, the following definitions apply:

"Agreement" means a contract between the area boards, state board, department, and state agencies to which funding is allocated.

"Audit" means a financial review by area boards of early childhood Iowa funds. Area boards that receive federal funds shall complete an audit of the funds. The audit must be a single audit if the area board received a total of federal funds from all funding sources in excess of the threshold defined in 2 CFR 200.501(b) as amended to December 31, 2023. Area boards that are not required to conduct a single audit under 2 CFR 200.501(b) as amended to December 31, 2023, may coordinate with the fiscal agent to conduct the required audit. The audit requirements shall be found in the online toolkit available on the department website.

"Early childhood Iowa area board" or *"area board"* means the same as defined in Iowa Code section 256I.1.

"Early childhood Iowa state board" or *"state board"* means the same as defined in Iowa Code section 256I.1.

[**ARC 8068C**, IAB 6/12/24, effective 7/17/24]

441—122.2(256I) Fiscal oversight.

122.2(1) In consultation with the state board, the department has adopted policies to oversee the fiscal responsibilities of area boards.

122.2(2) The department will:

a. Review the internal controls of all disbursements of early childhood Iowa funding;

b. Approve the process for issuing agreements with area boards;

c. Approve and sign all agreements between the area boards and the state for the purposes of Iowa Code chapter 256I;

d. Develop a policy for the disbursement of funds;

e. Require an audit, conducted by an independent agency, of the early childhood Iowa funds managed by area boards. The minimum requirements and frequency of audits for the area boards shall be determined and approved by the state board;

f. Ensure that all area boards secure liability insurance; and

g. Require that area boards submit a contract-monitoring schedule for their funded programs.

[**ARC 8068C**, IAB 6/12/24, effective 7/17/24]

These rules are intended to implement Iowa Code sections 256I.1 through 256I.12.

[Editorial change: IAC Supplement 6/14/23]

[Filed ARC 0178C (Notice ARC 0067C, IAB 4/4/12), IAB 6/27/12, effective 8/1/12]

[Editorial change: IAC Supplement 6/14/23]

[Filed ARC 8068C (Notice ARC 7362C, IAB 1/24/24), IAB 6/12/24, effective 7/17/24]

CERTIFICATE OF NEED PROGRAM

CHAPTER 123
CERTIFICATE OF NEED PROGRAM

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

441—123.1(135) Definition. For purposes of this chapter, the following definition applies:

"Long-term (acute) care hospital" means a hospital that has been approved to participate in the Title XVIII (Medicare) program as a long-term care hospital-prospective payment system (LTCH-PPS) hospital in accordance with 42 CFR Part 412 as amended to August 1, 2025.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.2(135) Determination of reviewability. A sponsor of a proposed project may electronically submit a written request for a determination of reviewability as to whether the project requires a certificate of need.

123.2(1) If it is determined that a certificate of need is required, the department will notify the sponsor of the determination of reviewability and the sponsor will be allowed to submit an electronic application immediately.

123.2(2) If it is determined that a certificate of need is not required, the department will notify the sponsor of the determination of nonreviewability.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.3(135) Submission of application.

123.3(1) Application form.

a. A sponsor of a proposed project for a new or changed institutional health service will submit to the department an electronic application for certificate of need using the appropriate application form found on the certificate of need website. All information requested in the application form is required in the absence of a waiver by the department.

b. An original application and all attachments shall be submitted electronically.

c. The department will establish and maintain electronic files on each application.

123.3(2) The application fee specified in Iowa Code section 135.62(1) is based on the total cost of the project, including site costs, land improvements, facility costs, movable equipment, and financing costs.

a. The fee for leased or donated new institutional health services is calculated in the same manner as if the new institutional health services were purchased.

(1) The leased equipment fee is based on total value of the lease, plus sales tax, delivery and installation.

(2) The lease of space includes the cost of a one-year lease payment for the space, in addition to other costs associated with the project.

(3) Financing costs are not applicable on leases or cash purchases.

b. The application fee will be refunded by the department for any application that is voluntarily withdrawn from the review process in the amounts specified in Iowa Code section 135.62(1).

c. For purposes of this subrule and Iowa Code section 135.62(1), "submission" means the day the application is received by the department.

123.3(3) The notice of an accepted application issued pursuant to Iowa Code section 135.65(2) will inform the applicant and affected persons of the deadlines for the electronic submission to the department of written public comments or other materials.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.4(135) Organizational procedures.

123.4(1) The department will evaluate the application against the criteria specified in Iowa Code section 135.63.

123.4(2) Public comments on an application.

a. The department will receive written public comments on an application during a time frame prescribed by the department for each application.

b. Public hearings conducted pursuant to Iowa Code section 135.65(3)*"b"* are not contested cases.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.5(135) Summary review. Summary review may be utilized at the discretion of the department pursuant to Iowa Code section 135.66. An applicant requesting a summary review will abide by the following procedures:

123.5(1) An applicant will electronically submit a written request for summary review and a copy of the application and all attachments.

123.5(2) The eligibility of an application for summary review pursuant to Iowa Code section 135.66 will be at the department's discretion.

123.5(3) Upon receipt of a request for summary review, an application, and the fee required by Iowa Code section 135.62(1), the department will notify the applicant within 15 calendar days if the application is complete and if a summary review will be granted.

123.5(4) If an application is deemed incomplete, the department will state specifically in writing what information is needed to make the application complete.

123.5(5) If the department notifies an applicant that a summary review will not be performed, this decision is binding on the applicant and the application will be entered into the formal review process on the date of written notice that such application will not be reviewed summarily.

123.5(6) A summary review of an application for a certificate of need will be completed within 60 calendar days of the acceptance of an application by the department. Summary review will follow the process outlined on the department's website.

123.5(7) At any time during the summary review process, an application may be withdrawn without prejudice from the process. An applicant may then submit the application for a formal 90-day review.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.6(135) Extension of review time.

123.6(1) A formal review of an application for a certificate of need pursuant to Iowa Code section 135.65 may be extended by the department on the basis of any of the following criteria:

a. In order to review competing applications simultaneously;

b. In the case of technologically innovative equipment, to obtain additional information necessary to evaluate the proposal. The department will specify in writing such additional information as necessary;

c. At the request of an applicant;

d. At the request of the department in order to allow additional time for deliberation on all evidence present. The department will specify the time of the delay and the date on which the final decision will be rendered.

123.6(2) An extension by the department made pursuant to subrule 123.6(1) will in no case be more than 30 calendar days beyond the time a decision is required under Iowa Code section 135.68 unless the applicant and the department agree.

123.6(3) Where none of the provisions of subrule 123.7(1) are applicable and where an application will be automatically denied because of the expiration of time required by Iowa Code section 135.68 for the issuance of a written decision by the department, the department will notify the applicant of the likelihood of an automatic denial and will ask the applicant to request in writing an extension of the review time.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.7(135) Rehearing of certificate of need decision.

123.7(1) An applicant or any affected person who has participated or sought unsuccessfully to participate in the formal review procedure prescribed in Iowa Code section 135.65 may, for good cause shown, electronically file an application for rehearing with the department stating the specific grounds therefor and the relief sought within 20 calendar days after the date of the issuance of the final decision on an application for certificate of need.

123.7(2) Grounds for rehearing include but are not limited to:

a. New significant, relevant information that was unavailable at the date of the hearing;

b. Significant changes in factors or circumstances relied upon by the department in reaching its decision;

c. Demonstration that the department has materially failed to follow its adopted procedures in reaching its decision; or

d. Such other bases as the department determines constitute good cause.

123.7(3) An application for rehearing is deemed to have been denied unless the department grants the application in writing within 20 calendar days after its filing.

123.7(4) If the application for rehearing is granted, the department may issue an order modifying the initial final order. At the department's discretion, public hearing may be granted on the application for rehearing and notice will be provided ten calendar days prior to the rehearing to the person applying for rehearing, the applicant and other affected persons upon request.

123.7(5) The department will issue the final decision on rehearing, stating the basis for its decision, within 60 calendar days after the application for rehearing was granted or 60 calendar days after public hearing or rehearing, whichever is later.

123.7(6) If a rehearing is not requested or an affected party remains dissatisfied after the request for rehearing, an appeal may be taken in the manner provided by Iowa Code chapter 17A. A request for rehearing is not required prior to appeal under Iowa Code section 17A.19.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.8(135) Finality. The certificate of need application process is continuous beginning with submission of an application through issuance of a final decision by the department subject to judicial review under Iowa Code chapter 17A.

123.8(1) The following stages of the process are intermediate and subject to judicial review only to the extent the stages meet criteria for intermediate review under Iowa Code section 17A.19:

a. A decision by the department pursuant to rule 441—123.2(135) that a proposed project does not require a certificate of need;

b. A decision by the department to conduct summary review; and

c. The rejection of an application by the department that fails to provide all information required under Iowa Code section 135.62(1).

123.8(2) The following stages of the process are final decisions subject to judicial review as final agency action under Iowa Code section 17A.19:

a. A decision by the department to disallow summary review;

b. A decision by the department that a proposed project does not require a certificate of need;

c. A decision by the department to approve or deny an application;

d. The department's final decision on an application for rehearing; and

e. A decision by the department to revoke a certificate of need pursuant to rule 441—123.10(135).

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.9(135) Request for extension of certificate.

123.9(1) A request by an applicant for an extension of a certificate of need will be filed with the department using the form available on the certificate of need website no later than 30 days prior to the expiration of the certificate of need.

123.9(2) When an extension has been requested, the department will approve or deny the request prior to expiration of the certification. The certificate of need may be revoked by the department at the end of the certification period for insufficient progress in developing the project.

123.9(3) If an extension is denied, an applicant has the right to appeal under the provisions of Iowa Code section 135.69.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.10(135) Application changes after approval.

123.10(1) Once a project has been approved by the department, no changes that vary from or alter the number of approved beds, the approved services or the approved cost by an amount indicated in subrule

123.10(2) may be made unless requested by the applicant and approved by the department. Requests should be filed with the department electronically.

123.10(2) An increase in the actual cost of the project over and above that originally approved will automatically generate review by the department if the increase exceeds the originally approved amount by:

a. Fifteen percent for projects up to $999,999.99;

b. Twelve percent for projects from $1 million to $4,999,999.99;

c. Eight percent for projects $5 million and over.

An increase in the approved cost that falls below the above percentages will be reported to the department.

123.10(3) Failure to notify and receive permission of the department to change the project as originally approved may result in the imposition of sanctions as provided in Iowa Code section 135.72. The department may make a recommendation regarding the imposition of a sanction and the amount of the fine to be imposed.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—123.11(135) Sanctions. Hearings to determine class I or class II violations pursuant to Iowa Code section 135.72 will be conducted in accordance with 441—Chapter 7.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

These rules are intended to implement Iowa Code sections 135.61 through 135.78.

[Filed ARC 0320D (Amended Notice ARC 0175D, IAB 4/1/26; Notice ARC 9796C, IAB 12/10/25), IAB 5/27/26, effective 7/1/26]

[Filed ARC 0769D (Notice ARC 0618D, IAB 9/30/26), IAB 11/25/26, effective 1/1/27]

CHAPTER 124
STANDARDS FOR CERTIFICATE OF NEED REVIEW

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

441—124.1(135) Computerized tomography standards.

124.1(1) *Purpose and scope.*

a. These standards are measures of some of those criteria in Iowa Code section 135.63(1)*"a"* through *"l."* Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these computerized tomography standards include:

(1) Proposals to commence or expand the capacity of computerized tomography services.

(2) Any other applications that relate to computerized tomography services.

124.1(2) *Definitions.* The following definitions apply to the terms used in this rule:

"Applicant" means a facility or a consortium of facilities within an area or a physician or group of physicians.

"Computerized tomographic (CT) scanner" means a diagnostic tool that rotates around the body and that sends X-ray beams through the body or brain. The X-ray beams that emerge from the body or brain are absorbed by a detector. Differences in the amount of X-rays absorbed by the detector indicate differences in tissue density. As the scanner rotates, it takes many images of a volume or cross-section. The images on the detector are transmitted to a computer that displays on a monitor a reconstructed cross-sectional slice or volume. Contrast media is often injected to alter absorption of the detector. If the scan is repeated, it is called enhancement. Studies of the heart, arteries and veins may be done with contrast only.

"CT consortia" means a cooperative venture in which two or more institutions form a separate entity that is created for the purpose of owning, leasing, planning for, and maintaining the use of the scanner. Each facility in the consortium maintains its autonomy for all other services.

"Emergency medical service (EMS) level II trauma service" means the level of various services and staffing that qualify a facility to be designated by the department, using the facilities categorization criteria of such services that is in effect on the date of the enactment of this standard.

"Enhanced scan" means a scan performed on a patient who has been administered a contrast medium so that specific organs or areas of the body will be displayed more distinctly on the scan image.

"General imaging procedures" means a radiological diagnostic procedure performed on an X-ray machine or similar radiological diagnostic instrument.

"Head scanner" means a scanner capable of imaging only the brain and structures adjacent to the head.

"Minimum shared-market area for a scanner" (hereafter referred to as "area") means the smallest geographic area within which any scanner installation is judged to affect the utilization rate of any other scanner in the community (as defined by the U.S. Bureau of the Census) or a standard metropolitan statistical area (where an area is so designated).

"Radiotherapy service" means the therapeutic application of megavoltage radiation, using a linear accelerator or cobalt unit. The availability of such service at a hospital would necessitate personnel trained in the therapeutic application of radiology.

"Shared service agreement" means a multi-institutional arrangement for coordination or consolidation of services or sharing of support services. Among the various types of arrangements are referred services, purchased or joint contract services, multisponsored services and regional services.

"Whole body scanner" means a scanner capable of imaging the entire body.

124.1(3) *Determination of need.*

a. An applicant who does not have a scanner or an applicant who has a scanner and seeks a certificate for one or more additional scanners.

(1) An applicant in areas with no other scanners.

1. An applicant must have performed at least 30,000 general imaging procedures during the past calendar year or 12 months, or

2. An applicant must demonstrate that during the past calendar year or 12 months, the applicant has performed diagnostic procedures equivalent to 1,500 head equivalent CTs (HECTs), using the following: 100 percent of the number of patients referred to other facilities for CT diagnosis × 1.75 (in the case of head scans) and 2.75 (in the case of body scans).

(2) An applicant in an area with one or more scanners.

1. An applicant must meet the requirement of need described in subparagraph 124.2(3)*"a"*(1), and

2. The average level of utilization for scanners within the area was at least 3,000 HECTs (plus or minus 10 percent) for the past calendar year or 12 months. The average level of utilization will be determined by adding the number of HECTs performed during the period at all area facilities divided by the number of facilities.

3. University of Iowa Health Care is specifically exempted from consideration under numbered paragraph 124.3(2)*"a"*(2)"2" because it has a service area that encompasses the entire state and adjoining states. The utilization statistics for scanners at the University of Nebraska Medical Center and Creighton University Medical Center – Bergan Mercy (both in Omaha) will not affect the need for scanners at hospitals in Council Bluffs.

b. Replacement scanners—applicant who currently has a scanner.

(1) An applicant seeking to replace a scanner with another scanner, head or body.

1. An applicant must demonstrate that the applicant's use of the applicant's current scanner was at least at the operating capacity level during the last calendar year or 12 months, or

2. An applicant must demonstrate that the applicant's use of the applicant's current scanner was at least below the operating capacity level, but above the 1,500 CT scan level, and the applicant must demonstrate reasons for permanently utilizing the applicant's scanner below operating capacity level and demonstrate that discontinuation of the applicant's scanner service would impair the applicant's ability to respond to the emergency needs of the area. Reasons for utilizing the scanner below the capacity should include a unique patient or procedure mix that would define the capacity level differently for the applicant.

(2) Reserved.

124.1(4) *Costs and financial feasibility.* (Iowa Code section 135.63(1)*"f," "i,"* and *"p"*)

a. CT scanners should be depreciated over a period of not less than seven years. Remodeling shall be depreciated as appropriate by generally accepted accounting principles.

b. Cost-effectiveness. An applicant should demonstrate for the applicant and the health care system that the most cost-effective method of providing CT services has been chosen. A proposed new and replacement CT scanner's cost per CT scan should, when compared to the applicant's peers, demonstrate cost-effectiveness.

124.1(5) *Accessibility.* (Iowa Code section 135.63(1)*"c"* and *"d"*)

a. All scanners must be available to meet the needs of the communities the scanners are meant to serve.

b. Services should be provided to all patients regardless of the patients' ability to pay, taking into consideration the availability of those programs available in the state that serve the medically indigent.

c. An applicant will demonstrate a willingness to accept referrals for CT services from all area physicians.

124.1(6) *Quality.* (Iowa Code section 135.63(1)*"i"* and *"k"*)

a. Data on use and costs of the CT scanners should be submitted to the Iowa department of health and human services as a condition of approval. (Iowa Code section 135.63(1)*"a"* and *"h"*)

b. All scanners.

(1) An applicant must demonstrate that the applicant has on its staff or will acquire on its staff a full-time diagnostic radiologist trained in the use of the CT scanner or other physicians with comparable training and expertise.

(2) An applicant must document that the applicant has on its medical staff individuals who are qualified to operate a scanner and interpret and act upon the diagnostic results. Such documentation may include reference to board certification, apprenticeship, academic credentials or such other qualifications that would prompt a medical staff to accept the responsibility for offering this new service. An applicant that intends to acquire staff with the desired expertise should provide signed letters of intent from the

incoming medical personnel. An applicant that intends to upgrade the specialty skills of its staff should document a plan for training its current staff in the use of CT scanners.

(3) An applicant should have a complement of other diagnostic modalities available. An applicant seeking body scanners should also have available ultrasound and conventional X-ray services.

(4) An applicant should have the facilities for treating the conditions diagnosed by imaging with the scanner or should demonstrate referral agreements with treatment facilities in the event that the scanner will be used as a screening device.

(5) An applicant should have on its staff or available on a consultative basis the services of a biomedical engineer or medical physicist with special training in CT applications. These functions may also be provided by contract with the scanner manufacturer.

124.1(7) *Continuity.* (Iowa Code section 135.63(1)*"g," "h," "i,"* and *"k"*)

a. An applicant should demonstrate that an attempt was made to solicit letters of support from area hospitals and physicians to indicate a community need for the proposed service.

b. An applicant should provide documentation that emergency medical transport services will be available.

c. An applicant should demonstrate an emphasis on the availability of outpatient CT procedures and that an appropriate percentage of all CT procedures will be done on an outpatient basis.

124.1(8) *Acceptability.* (Iowa Code section 135.63(1)*"k"*) Providers of CT services should indicate a willingness to observe the rights of patients.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—124.2(135) Long-term care.

124.2(1) *Purpose and scope.*

a. These standards are measures of criteria found in Iowa Code section 135.63(1)*"a"* through *"g."* Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these standards include applications to:

(1) Construct, develop, offer new, modernize, replace, renovate, or relocate intermediate care or skilled nursing care beds in nursing homes or hospitals.

(2) Expand bed capacity in intermediate care or skilled nursing care facilities or designated units in hospitals.

124.2(2) *Definitions.* The following definitions apply to the terms used in this rule:

"Intermediate care facility" or *"ICF"* means any institution, place, building, or agency providing for a period exceeding 24 consecutive hours accommodation, board, and nursing services, the need for which is certified by a physician, to three or more individuals, not related to the administrator or owner thereof within the third degree of consanguinity, who by reason of illness, disease, or physical or mental infirmity require nursing services that can be provided only under the direction of a registered nurse or a licensed practical nurse.

"Skilled nursing facility" or *"SNF"* means any institution, place, building, or agency providing for a period exceeding 24 consecutive hours accommodation, board, and nursing services, the need for which is certified by a physician, to three or more individuals not related to the administrator or owner thereof within the third degree of consanguinity who by reason of illness, disease, or physical or mental infirmity require continuous nursing care services and related medical services but do not require hospital care. The nursing care services provided must be under the direction of a registered nurse on a 24-hour-per-day basis.

124.2(3) *Availability and need.* (Iowa Code section 135.63(1)*"c," "d," "e," "g,"* and *"h"*)

a. The following formula will be used as a means of projecting the approximate number of beds needed by level of care (intermediate or skilled nursing care) to serve the projected population one year into the future using county-level characteristics:

(1) County-level bed need = County-level bed-days / days in time period

County-level bed-days = exp(Linear Predictor)

Linear Predictor = Intercept

+ Weight for Log of Total Population × Log of Total Population

+ Weight for Percent age 65-74 × Percent age 65-74

+ Weight for Percent age 75-84 × Percent age 75-84
+ Weight for Percent age 85 plus × Percent age 85 plus
+ Weight for Level of care × Level of care
+ Weight for Time Trend × Time Trend
+ Weight for Level of care × Time Trend × Level of care × Time Trend
+ Month effect for applicable month
+ County effect for applicable county

(2) For the purposes of using this formula, the lower and upper bounds of the weights for each variable in this section can be found on the department's website at hhs.iowa.gov/certificate-need-con-program.

(3) Bed need formula projections will consider county of facility, seasonal variation in need, age range of population, future population change projections, and other relevant factors and controls.

(4) The department will review the bed need formula at least every three years.

b. For purposes of comparing "need" to "existing" beds in a given county, the following shall be considered in the calculation of "existing" beds:

(1) ICF and SNF beds licensed at freestanding facilities in the county.

(2) Additional ICF and SNF beds previously approved through certificate of need but not yet licensed.

(3) ICF and SNF beds in designated units in hospitals in the county.

c. The statistical calculation of bed need shall serve as a guideline for the department in reviewing need for the proposed long-term care beds. Other factors that may be considered by the department include but are not limited to:

(1) The availability and utilization of other ICF and SNF services in the county or within an applicant's service area.

(2) The availability and utilization of other long-term care services in nearby hospitals, such as skilled care available through the swing bed program.

(3) The availability of supportive living arrangements that may or may not be licensed as an RCF.

(4) The availability of home health and other in-home services.

(5) The availability of other services to the elderly.

(6) The availability of ICF and SNF services in neighboring counties.

(7) Utilization by out-of-state residents of facilities in counties bordering other states, where an applicant provides evidence that in-migration of long-term care patients exceeds out-migration to the bordering state.

(8) Programs and services directed at special populations whose needs cannot otherwise be met or whose needs cannot be met cost-effectively at other facilities.

d. In documenting need for a project, an applicant shall identify the service area and target population, including a description of the methodology used by the applicant in determining need for the requested beds and the expected sources of referrals. The applicant shall document that the number of beds requested is appropriate to address the identified need. The applicant shall also identify how the target population is currently being cared for and what hardship is being experienced by the absence of the proposed beds.

124.2(4) *Quality.* (Iowa Code section 135.63(1)*"i"* and *"k"*) An applicant shall document that the applicant has contacted the health and safety division of the department of inspections, appeals, and licensing to conform with physical standards, staffing requirements, and other licensing requirements to assess the potential for provision of quality care at the facility. When necessary, the applicant shall attempt to arrange an on-site visit to the facility to determine compliance with physical requirements and shall provide documentation of this site visit or attempts to arrange such a site visit.

124.2(5) *Continuity.* (Iowa Code section 135.63(1)*"g," "h,"* and *"k"*)

a. An applicant shall document the relationship of the facility's proposed services to other health and long-term care services in the community, such as physician and hospital services, habilitation, rehabilitation, transportation or other services. The facility should be capable of providing or arranging for the provision of a continuum of long-term care services.

b. A facility should be capable of providing or arranging for the provision of a comprehensive program of coordinated patient services. An applicant shall provide evidence of contracts for services, appropriate staffing patterns and ratios, and licensure of personnel as necessary.

124.2(6) *Accessibility and acceptability.* (Iowa Code section 135.63(1)*"c"* and *"d"*)

a. Population subgroups that have traditionally been underserved, such as adolescents, the elderly, women, racial minorities, mentally ill, intellectually disabled, and developmentally disabled, should be considered when planning for or reviewing long-term care facilities.

b. An applicant shall document to what extent Medicaid patients will be served by the proposed beds, using past Medicaid utilization as an indicator or, in the case of a new facility, projecting anticipated Medicaid utilization.

124.2(7) *Costs and financial feasibility.* (Iowa Code section 135.63(1)*"e," "f," "i,"* and *"p"*)

a. An applicant shall identify capital and operating costs associated with the project, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.

b. Construction costs shall be in line with construction costs of other similar projects.

c. An applicant shall provide budgets for the first three years of operation, including documentation of all assumptions used. The budget shall include anticipated sources of revenue, including the percentage of revenue from private pay, Medicaid, Medicare and other patient revenues.

d. Proposed charges per patient day should be justifiable when compared to current charges of other similarly licensed facilities in an applicant's service area or other similar facilities elsewhere in the state. If charges are significantly higher or lower, the applicant shall provide a description of proposed programs or services that explain the difference in charges.

These rules are intended to implement Iowa Code section 135.71.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—124.3(135) MRI services standards.

124.3(1) *Purpose and scope.*

a. These standards are measures of some of those criteria in Iowa Code section 135.63(1)*"a"* through *"q."* Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these standards include:

(1) Proposals to commence or expand the capacity of magnetic resonance imaging services.

(2) Proposals to replace a magnetic resonance imaging unit.

(3) Any other applications that relate to magnetic resonance imaging.

124.3(2) *Definitions.* The following definitions apply to the terms used in this rule:

"Area" means the community or a metropolitan statistical area (as defined by the U.S. Office of Management and Budget and used by the U.S. Census Bureau).

"Computed tomography" or *"CT"* means an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the X-ray absorption of beams projected through the body in the image plane.

"CT procedure" means a CT study of a single site of anatomic interest during an individual patient visit.

"Magnetic resonance imaging" or *"MRI"* means a diagnostic modality that employs a combination of magnetic and radio frequency fields and computers to produce images of body organs and tissues.

"MRI procedure" means each discrete MRI study of one patient.

"MRI unit" means the essential equipment and facility necessary to operate one MRI system.

124.3(3) *Availability and need.* (Iowa Code section 135.63(1)*"c," "d," "e," "g,"* and *"h"*)

a. An applicant in an area with no other MRI units. The applicant must document a future utilization of reasonably projected MRI procedure volume for the fiscal year period after projected installation.

b. An applicant in an area with one or more MRI units currently in operation or approved by certificate of need for operation.

(1) An applicant must meet the requirement of need described in paragraph 124.3(3)*"a,"* and

(2) The other MRI unit(s) within the area must have been operating at a minimum of 2,000 MRI procedures annually (or 500 in three months) or proportionately more if the MRI unit runs more than one ten-hour shift.

(3) If the annual utilization of the other MRI unit(s) within the area has been below 2,000 procedures, future utilization above that current level must be reasonably projected or reasons for permanently utilizing the equipment below the 2,000 procedure level must be demonstrated.

c. An applicant seeking to replace an MRI unit.

(1) An applicant must demonstrate that the existing MRI unit has been operating at the level of at least 3,000 procedures during the most recent annual period.

(2) If an applicant's annual utilization has been below 2,000 procedures, the applicant must reasonably project future utilization above that level or demonstrate reasons for permanently utilizing the equipment below that level.

d. An applicant seeking to add an additional MRI unit.

(1) An applicant must demonstrate that the existing MRI unit(s) has been operating at the level of at least 3,500 procedures during the most recent annual period.

(2) An applicant must demonstrate that the demand significantly exceeds the 2,000 procedures annually.

(3) If an applicant's annual utilization has been below 2,000 procedures, the applicant must reasonably project future utilization above that level or demonstrate reasons for permanently utilizing the equipment below that level.

124.3(4) *Quality and continuity.* (Iowa Code section 135.63(1)*"g," "h," "i,"* and *"k"*)

a. The proposed MRI unit should function as a component of a comprehensive inpatient or outpatient diagnostic service. The proposed MRI unit must have the following modalities on-site or through referral arrangements:

(1) Ultrasound.

(2) Computed tomography.

(3) Angiography.

(4) Nuclear medicine.

(5) Conventional radiography.

b. The proposed MRI unit must be located in a facility that has, either in-house or through referral arrangement, the resources necessary to treat most of the conditions diagnosed or confirmed by MRI. The following medical specialties must be available during MRI service hours on-site or by referral arrangements: neurology or neurosurgery, oncology and cardiology.

c. A proposal to provide a new or an expanded MRI must include satisfactory assurances that the services will be offered in a physical environment that conforms to federal standards, manufacturer's specifications, and licensing agencies' requirements.

d. An applicant must provide evidence that the proposed MRI equipment has been certified for clinical use by the U.S. Food and Drug Administration or will be operated under the approval and authority of an institutional review board whose membership is consistent with U.S. Department of Health and Human Services regulations.

e. An applicant for MRI should document that the necessary qualified staff are available to operate the proposed unit. The following minimum staff will be available to the MRI unit:

(1) A board-eligible or board-certified radiologist or any other board-eligible or board-certified licensed physician whose exclusive responsibility for at least a two-year period prior to submission of a certificate of need request has been in the acquisition and interpretation of clinical images. This individual shall have a knowledge of MRI through training, experience, or documented postgraduate education. The individual shall also have training with a functional MRI facility.

(2) Qualified engineering personnel, available to the institution during MRI service hours, with training and experience in the operation and maintenance of the MRI equipment.

(3) Diagnostic radiologic technologists or other certified technologists with expertise in CT or other cross-sectional imaging methods at a staffing level consistent with the hospital's expected MRI service volume.

(4) Other appropriate physicians shall be available during MRI service hours in clinical specialties, such as neurology or neurosurgery, oncology and cardiology.

f. An applicant shall demonstrate how emergencies within the MRI unit will be managed in conformity with accepted medical practice.

124.3(5) *Accessibility and acceptability.* (Iowa Code section 135.63(1)*"c"* and *"d"*)

a. An MRI facility should have adequate scheduled hours to avoid an excessive backlog of cases and to meet the needs of the communities the scanners are meant to serve.

b. Selection of patients for clinical MRI studies must guarantee equal access to all persons regardless of insurance coverage or ability to pay.

124.3(6) *Costs and financial feasibility.* (Iowa Code section 135.63(1)*"e," "f," "i,"* and *"p"*)

a. An applicant shall identify capital and operating costs associated with the proposed MRI unit, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.

b. An applicant shall provide budgets for the first three years of operation, including documentation and justification of all assumptions used.

c. An applicant must document its projected average cost per procedure and charge per procedure for the first three years. Charges for an MRI should be reasonably related to service cost and comparable to MRI charges at other facilities in the state.

d. An applicant shall demonstrate that alternatives were considered and the proposed application is the most cost-effective and will accomplish the goals of the project.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

441—124.4(135) PET services standards.

124.4(1) *Purpose and scope.*

a. These standards are measures of some of those criteria in Iowa Code section 135.63(1)*"a"* through *"q."* Criteria that are measured by a standard are cited in parentheses following each standard.

b. Certificate of need applications that are to be evaluated against these standards include:

(1) Proposals to commence or expand the capacity of positron emission tomography services.

(2) Proposals to replace a positron emission tomography unit.

(3) Any other applications that relate to positron emission tomography.

124.4(2) *Definitions.* The following definitions apply to the terms used in this rule:

"Area" means the community or a metropolitan statistical area (as defined by the U.S. Office of Management and Budget and used by the U.S. Census Bureau).

"Computed tomography" or *"CT"* means an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the X-ray absorption of beams projected through the body in the image plane.

"Cyclotron" means an apparatus for accelerating protons or neutrons to high energies by means of a constant magnet and an oscillating electric field.

"Magnetic resonance imaging" or *"MRI"* means a diagnostic modality that employs a combination of magnetic and radio frequency fields and computers to produce images of body organs and tissues.

"PET procedure" means an image-scanning sequence derived from a single administration of PET, equated with a single injection of the tracer.

"Positron emission tomography" or *"PET"* means an imaging method in which positron-emitting radionuclides, which are produced either by a cyclotron or generator, and a nuclear camera are used to create pictures of organ function rather than structure.

"Radiopharmaceutical" means a radioactive pharmaceutical used for diagnostic or therapeutic purposes.

"Single photon emission computed tomography" or *"SPECT"* means a camera-based imaging system using the radionuclides in the routine practice of nuclear medicine.

124.4(3) *Availability and need.* (Iowa Code section 135.63(1)*"c," "d," "e," "g,"* and *"h"*)

a. An applicant in an area with no other PET units.

(1) An applicant should demonstrate a reasonable potential utilization of a PET unit based on diversified inpatient and outpatient case mix thresholds, including:

1. Intracranial cases.

- Primary brain tumors: 50 per year.
- Metastasis: 100 per year.

- Cerebral vascular disease: 200 per year.
- Organic brain disease and dementia/psychiatric diagnoses (including epilepsy-seizure disorders): 500 per year.
- Spinal: 100 per year.

2. Cardiovascular cases.

- Ischemic heart disease (including acute and chronic infarction): 1,200 per year.

3. Neoplasms (head, neck, thorax (excluding heart), abdomen, pelvic, prostate and musculoskeletal): 1,300 per year.

(2) An applicant should have other diagnostic capabilities, on-site or through referral arrangements, with appropriate volumes including:

	Proposed Threshold
Nuclear medicine imaging services	5,600
Single photon emission computed tomography (including brain, bone, liver, gallium and thallium stress)	1,600
CT	8,000
MRI	2,400

(3) An applicant should demonstrate secondary and tertiary service capability, on-site or through referral arrangements, including cardiac surgery, cardiology, internal medicine, general surgery, hematology/oncology, neurology, pathology, thoracic surgery and psychiatry.

b. An applicant in an area with one or more PET units currently in operation or approved by the certificate of need program for operation.

Existing PET units within the area (whether basic or enhanced) should have been operating at a minimum of 1,000 PET procedures during the most recent annual period as reported to the certificate of need program according to paragraph 124.4(4)*"e."*

124.4(4) *Quality and continuity.* (Iowa Code section 135.63(1)*"g," "h," "i,"* and *"k"*)

a. A proposed PET unit should function as a component of a comprehensive inpatient or outpatient diagnostic service. The proposed PET unit should have the following modalities (and capabilities) on-site or through referral arrangements:

(1) CT.

(2) MRI.

(3) Nuclear medicine—cardiac, SPECT.

(4) Conventional radiography.

b. A proposed PET unit should be located in a facility that has, either in-house or through referral arrangement, the resources necessary to treat most of the conditions diagnosed or confirmed by PET. The following medical specialties should be available during PET service hours on-site or by referral arrangements: cardiology, neurology, neurosurgery, oncology, and psychiatry.

c. A proposal to provide new or expanded PET must include satisfactory assurances that services will be offered in a physical environment that conforms to federal standards, manufacturer's specifications, and licensing agencies' requirements. The following areas are to be addressed:

(1) Quality control and assurance of radiopharmaceutical production of generator- or cyclotron-produced agents;

(2) Quality control and assurance of PET tomograph and associated instrumentation;

(3) Radiation protection and shielding;

(4) Radioactive emissions to the environment.

d. An applicant will provide evidence that the proposed PET equipment has been certified for clinical use by the U.S. Food and Drug Administration or will be operated under the approval and authority of an institutional review board whose membership is consistent with U.S. Department of Health and Human Services regulations.

e. An applicant for PET will document that the necessary qualified staff are available to operate the proposed unit. The applicant will document the PET training and experience of the staff. The following minimum staff will be available to the PET unit:

(1) One or more nuclear medicine imaging physician(s) available to the PET unit who have been licensed by the state for the handling of medical radionuclides and whose primary responsibility for at least a one-year period prior to submission of the certificate of need application has been in acquisition and interpretation of tomographic images. This individual shall have knowledge of PET through training, experience, or documented postgraduate education. The individual shall also have training with a functional PET facility.

(2) Qualified PET radiochemist or radiopharmacist personnel available to the facility during PET service hours with at least one year of training. The individual(s) will demonstrate experience in the testing of chemical, radiochemical, and radionuclidic purity of PET radiopharmaceutical syntheses.

(3) Qualified engineering and physics personnel available to the facility during PET service hours with training and experience in the operation and maintenance of the PET equipment.

(4) Qualified radiation safety personnel available to the facility at all times with training and experience in the handling of short-lived positron-emitting nuclides.

(5) Certified nuclear medicine technologists with expertise in computed tomographic nuclear medicine imaging procedures at a staffing level consistent with the proposed center's expected PET service volume.

(6) Other appropriate personnel should be available during PET service hours, which may include certified nuclear medicine technologists, computer programmers, nurses, and radiochemistry technicians.

f. An applicant will demonstrate how emergencies within the PET unit will be managed in conformity with accepted medical practice.

124.4(5) *Accessibility and acceptability.* (Iowa Code section 135.63(1)*"c"* and *"d"*)

a. A PET facility should have adequate scheduled hours to avoid an excessive backlog of cases.

b. Selection of patients for clinical PET studies will guarantee equal access to all persons regardless of insurance coverage or ability to pay.

c. In addition to accepting patients from participating institutions, a facility performing clinical PET procedures should accept appropriate referrals from other local providers. These patients will be accommodated to the extent possible by extending the hours of service and by prioritizing patients according to standards of need and appropriateness rather than source of referral.

124.4(6) *Costs and financial feasibility.* (Iowa Code section 135.63(1)*"e," "f," "i,"* and *"p"*)

a. An applicant will identify capital and operating costs associated with a proposed PET unit, identify sources of funding to cover those costs, and demonstrate that the project is financially feasible.

b. An applicant will provide budgets for the first three years of operation, including documentation and justification of all assumptions used.

c. An applicant will document its projected average cost per procedure and charge per procedure for the first three years. Charges for PET should be reasonably related to service cost and comparable to PET charges at other facilities in the state.

d. An applicant should verify whether the service is eligible for reimbursement by public and private third-party payers.

e. An applicant should demonstrate that alternatives were considered and the proposed application is the most cost-effective and should accomplish the goals of the project.

[**ARC 0320D**, IAB 5/27/26, effective 7/1/26; **ARC 0769D**, IAB 11/25/26, effective 1/1/27]

These rules are intended to implement Iowa Code sections 135.61 through 135.78.

[Filed ARC 0320D (Amended Notice ARC 0175D, IAB 4/1/26; Notice ARC 9796C, IAB 12/10/25), IAB 5/27/26, effective 7/1/26]

[Filed ARC 0769D (Notice ARC 0618D, IAB 9/30/26), IAB 11/25/26, effective 1/1/27]

CHAPTER 125
KINSHIP FOSTER CARE APPROVAL STANDARDS

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/1/31

441—125.1(237) Definitions.

"Approval" means the authorization granted to a kinship caregiver by the department through an expedited process to provide child foster care and allows the kinship caregiver to receive maximum financial support and to obtain the information and resources necessary to meet the needs of a child under a court-ordered placement with the kinship caregiver.

"Approved kinship caregiver" means a kinship caregiver granted approval for kinship foster care.

"Child," for the purpose of this chapter, only means the child or children who are in foster care.

"Consanguinity" means relatives who share a common biological ancestor with the child.

"Corporal punishment" means the intentional physical punishment of children.

"Fictive kin" means an adult person who is not a relative of a child but who has an emotionally significant and positive relationship with a child or the child's family.

"Kinship care" means the care of a child by a relative or fictive kin providing full-time nurturing and protection.

"Kinship foster care" means an expedited process to approve a kinship caregiver for foster care through providing the necessary information, resources, and maximum financial support to the caregiver to meet the needs of the child court ordered to placement in the caregiver's care.

"Kinship foster caregiver" means a relative or fictive kin providing care for a child who is approved for kinship foster care.

"Reasonable and prudent parent standard" means the same as defined in Iowa Code section 237.1.

"Recruitment and retention contractor" means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents or any of its subcontractors.

"Relative" means an individual related to the child within the fourth degree of consanguinity or affinity, by marriage, or through adoption. This includes the parent of a sibling of the child if the sibling's parent's parental rights were not previously terminated in relation to the child.

"Service area manager" means the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.2(237) Application for approval.

125.2(1) *Right to apply.* A relative or fictive kin of a child who has been court-ordered to placement in the relative or fictive kin's care can apply for kinship foster care approval. All applicants must be at least 18 years of age.

125.2(2) *Referrals.* A relative or fictive kin caregiver wishing to apply for kinship foster care approval shall be referred by the department or the department's contractor for kinship navigator services. The department's recruitment and retention contractor in the applicable service area shall provide the application packet and assist in completing the approval process with the applicant.

125.2(3) *Decision to operate a kinship foster home.* When an applicant decides to operate a kinship foster family home, the applicant shall complete the Kinship Foster Care Approval Application.

125.2(4) *Withdrawal of an application.* The applicant shall report the withdrawal of an application promptly to the department.

125.2(5) *Evaluation of the application.* Each application will be evaluated by the department to ensure that all standards are met.

a. Before it results in adverse action, a founded child abuse report of a kinship foster parent applicant will be evaluated by the department to determine if the founded abuse merits prohibition of approval.

b. The department will evaluate founded child abuse reports on a case-by-case basis. Considerations the department will take include but are not limited to whether the abuse was an isolated incident or is symptomatic of a broader, systemic problem.

125.2(6) *Reports and information.* The applicant shall furnish all requested reports and information relevant to the approval determination to the department.

125.2(7) *Applications for reapproval.* The department or its agent will send an application for reapproval 90 days before the approval expires. Applications for reapproval shall be made on the form specified in subrule 125.2(3).

a. Applications for reapproval shall be made no less than 30 days but no more than 90 days before the approval expires.

b. Applications for reapproval of a kinship foster family approval shall be submitted to the recruitment and retention contractor.

c. The department will approve or deny an application for reapproval as described in rules 441—125.3(237) and 441—125.4(237).

125.2(8) *Notification.* The department will notify an applicant of the approval or denial of an initial application within 60 days of the date that the applicant is referred to the recruitment and retention contractor. The department will notify an applicant regarding reapproval within 30 days of the expiration of the initial approval.

125.2(9) *Approval.* Approved kinship foster caregiver applicants will be approved for a term of two years.

a. Thereafter, the caregiver shall apply for reapproval every two years based on the requirements of subrule 125.2(7).

b. A new notice of approval is required any time the caregiver moves to a new home.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.3(237) Denial.

125.3(1) The department will deny the Kinship Foster Care Approval Application when:

a. The applicant, or any person residing in the home other than a foster child, has been convicted of a crime unless the department has evaluated the crime and concluded that the crime does not merit prohibition of approval.

b. The applicant, or any person residing in the home other than a foster child, has a record of founded child abuse unless the department has evaluated the founded abuse and concluded that the abuse does not merit prohibition of approval.

c. There is just cause due to a condition or combination of conditions that cannot be improved and prevents the kinship caregiver from caring for the child's physical, emotional, medical, or educational needs.

125.3(2) Reapplications shall be denied based on the same criteria as initial applications.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.4(237) Approval procedure.

125.4(1) *Application.* Applicants for an initial approval to become a kinship foster home shall submit the Kinship Foster Care Approval Application forms directed in rule 441—125.2(237).

125.4(2) *Record checks.* Prior to approval of an application for kinship foster care, applicants shall pass the record check procedures identified in rule 441—125.7(237).

125.4(3) *Home study.* The recruitment and retention contractor shall complete a kinship foster care home study.

a. Process. Information for the home study is gathered primarily through a face-to-face interview with the identified kinship caregiver(s) in the home. Tribal agencies may also be involved in conducting home studies for American Indian and Alaska Native children. 42 U.S.C. §671(a)(26)(B) as amended to August 1, 2025, provides that any receiving state must treat any tribal home study report as meeting the requirements imposed by the state for the completion of a home study.

(1) The contractor shall hold at least one face-to-face interview with the applicant(s) with one of the interviews taking place in the applicant's home.

(2) A physical assessment of the home is required. The contractor shall use a Kinship Foster Care Home Study form to assess the physical structure of the home to verify it is safe for the child.

b. Caregiver assessment. The kinship caregiver shall be assessed to evaluate the caregiver's ability to meet the needs of the court-ordered placed child. The assessment will include the following criteria:

(1) The applicant's ability to provide for the child's physical, medical, and emotional needs; to respect the child's ethnic and religious identity; and to support the child's overall well-being.

(2) The safety of the child in relation to any animals that live on the applicant's property.

(3) Knowledge of the child's situation, the caregiver's relationship with the child, the child's family and knowledge of the child's situation and department involvement.

(4) Agreement to abstain from using physical forms of discipline.

(5) Understanding of the reasonable and prudent parenting standard and how to successfully apply the standard.

(6) The caregiver's willingness to access resources and additional supports needed for placement stability to meet the needs of their family and the child placed in their care.

(7) The caregiver's and other household members' current health status, including current prescription medications.

(8) The caregiver's previous or current challenges with mental health, substance use or both and the potential impact it may have on the caregiver's ability to care for the child.

(9) Assessment of whether previous violence was experienced in the caregiver's home and how it has been addressed.

(10) The caregiver's willingness and ability to ensure the child's attendance at school; appointments for medical, dental, and vision; activities; and to ensure family interactions with parents and siblings.

(11) Assessment of the caregiver's ability and willingness to commit to the child, to work with the department, and to be considered as a long-term permanency option.

(12) Understanding of household composition, who has access to the child, other adults and children in the household, relationship status of household members and family dynamics.

(13) Description of the caregiver's available formal and informal supports to ensure child safety and well-being.

c. Physical home assessment. The physical home assessment shall assess the following areas of the applicant's home and address necessary steps to mitigate concerns when identified:

(1) General description of the dwelling, including the number of bedrooms, bathrooms, and shared areas of the home.

(2) Determination of any signs of home infestation by rodents, insects, or other pests.

(3) Existence of external hazards, such as accessibility of pools/hot tubs, nearby bodies of water, railroad tracks, waste materials, or contaminated water.

(4) Existence of internal hazards that pose a risk of harm created by the physical structure of the home, such as broken or missing stairs, exposed wires, large holes in the floor, broken windows, or other physical hazards.

(5) Accessibility of hazardous materials or items in the home or on the property and the means to make them inaccessible to the child in an age-appropriate way or used with appropriate supervision.

(6) Evaluation of a child's access to the following:

1. Firearms and projectile weapons.
2. Medications.
3. Strong or toxic chemicals, such as detergents, bleach, and gasoline.
4. Tools, machinery, farm equipment, lawn mowers, and trampolines.
5. Potable water.

(7) Evaluation of the sleeping arrangements for children placed in the home, including:

1. Planned sharing of sleeping spaces.
2. Where children will have privacy to change clothes.
3. If supports are needed to provide beds, bedding, or establish opportunities for privacy.
4. Discussion of safe sleeping practices for children aged one and younger.

(8) Ability to ensure the child's access to age-appropriate personal hygiene (bathing, brushing teeth, wearing clean clothing).

(9) Ability to protect the child in an age-appropriate manner from pets or animals.

(10) Age-appropriate safe seat restraints (car seat, seatbelt, etc.) in personal vehicles used to transport the child.

(11) Ability to provide the child ongoing access to adequate, nutritious, age-appropriate food, including the ability to keep perishable items cold.

(12) Understanding of the child's dietary needs related to cultural/religious traditions, medical needs, and allergies.

(13) A plan for fire safety, including an escape plan and smoke detectors.

(14) Ability to create a safety plan that includes the ability to contact emergency services for assistance within a reasonable distance (neighbor's home, local business, etc.)

(15) Description of support mechanisms needed for the caregiver to address any barriers to meeting the physical needs of the home to ensure the safety and well-being of the child and steps taken to address the needs during the approval process.

d. Written report. The recruitment and retention contractor shall prepare a written report of the caregiver assessment. This assessment shall include a recommendation for approval or denial of the application and any other pertinent information in making the recommendation. The home study shall be maintained in the kinship caregiver's record maintained by the department.

125.4(4) *Decision and notice of action.* The department will use the home study and the recommendation of the recruitment and retention contractor to approve or deny a caregiver for kinship foster care.

a. The department will notify the family of the decision in writing.

b. If the department does not approve the home study, a notice will be issued according to the provisions of 441—Chapter 16 and state the reasons for that decision as listed in rule 441—125.3(237).

c. A denial may be appealed pursuant to the provisions set forth in 441—Chapter 2506.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26; Editorial change: IAC Supplement 6/10/26]

441—125.5(237) Involvement of kin.

125.5(1) *Support by kinship foster caregiver.* Kinship foster caregivers shall support the involvement of biological or adoptive parents and other relatives of the child unless this involvement is evaluated and documented by the department to be detrimental to the child's well-being.

125.5(2) *Nature of involvement.* The extent and nature of the involvement of the biological or adoptive parents and other relatives shall be determined by the caseworker in consultation with the kinship foster caregivers, biological or adoptive parents, and other members involved with the child and family.

125.5(3) *Cultural connections.* Throughout the provision of care, the kinship foster caregiver shall actively ensure that the child stays connected to the child's kin, culture, and community as required in the child's case permanency plan.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.6(237) Information on the child placed in the home.

125.6(1) *Information about the child.* Kinship foster caregivers shall maintain a separate file of information on the child placed in the home to include contact information for all medical, dental, vision, hearing and mental health professionals for the child; current medications for the child; school reports and school pictures received; and the date, name, address and phone number of the person to whom the child was discharged at the end of placement. This file shall be provided to the department or the child's parent or guardian when the child leaves the placement.

125.6(2) *Confidentiality.* Kinship foster caregivers shall maintain confidentiality regarding the child in their placement, except as required to comply with rules on mandatory reporting of child abuse and with the child's case permanency plan. Kinship foster caregivers shall not without parent, guardian and department consent post pictures or information concerning the child on any internet website.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.7(237) Record checks. Record checks are required for each foster parent applicant and for anyone who is 18 years of age or older living in the home of the applicant. The purpose of the record

checks is to determine whether any of these persons has any founded child abuse or dependent adult abuse reports or criminal convictions or has been placed on the sex offender registry.

125.7(1) *Procedure.* The department's contractor for recruitment and retention shall assist applicants in completing required record checks, including fingerprinting.

125.7(2) *Iowa records.* Each applicant and anyone who is 18 years of age or older living in the home of the applicant shall be checked for records with:

a. The Iowa central abuse registry;

b. The Iowa division of criminal investigation;

c. The Iowa sex offender registry; and

d. Iowa Courts Online.

125.7(3) *Other records.* Each applicant and any other adult living in the household shall also be checked for records on the child abuse registry of any state where the person has lived during the past five years. Each adult age 18 years of age or older shall also be fingerprinted for a national criminal history check.

125.7(4) *Evaluation of record.* If the applicant or anyone living in the home has a record of founded child or dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department will not approve the applicant for kinship foster care unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

125.7(5) *Exclusion.* An evaluation will not be performed if the person has been convicted of:

a. A felony offense as set forth in Iowa Code section 237.8(2)*"a"*(3); or

b. A crime in another state that would be a felony as set forth in Iowa Code section 237.8(2)*"a"*(3).

125.7(6) *Scope.* The evaluation will consider the nature and seriousness of the founded child or dependent adult abuse or crime in relation to:

a. The position sought or held;

b. The time elapsed since the abuse or crime was committed;

c. The circumstances under which the crime or founded abuse was committed;

d. The degree of rehabilitation;

e. The likelihood that the person will commit the abuse or crime again; and

f. The number of abuses or crimes committed by the person.

125.7(7) *Evaluation form.* The person with the founded child or dependent adult abuse or criminal conviction report shall complete and return to the department the Record Check Evaluation Form, within ten calendar days of the date of receipt, to be used to assist in the evaluation. Failure of the person to complete and return the Record Check Evaluation Form to the department within the specified time frame shall result in denial of approval.

125.7(8) *Evaluation decision.* Centralized service area staff or designees will conduct the evaluation and make the decision. The department will inform the subject of the decision and describe the basis of the decision using the criteria specified in subrule 125.7(6). The department will send the form to the person on whom the evaluation was completed:

a. Within 30 days of receipt of the completed form, or

b. When the person whose record is being evaluated fails to complete the evaluation form within the time frame specified.

125.7(9) *Reapproval.* Applicants approved for kinship foster care who apply for reapproval shall be subject to the same checks as new applicants, except for fingerprinting. The department will evaluate only abuses and convictions of crimes that occurred since the last record check. The evaluation will be conducted using the same process as described in rule 441—125.7(237).

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.8(237) Medical examinations and health care of the child.

125.8(1) *Medical and dental care.* Kinship foster caregivers shall keep the child's department case manager informed of any medical and dental appointments as well as any treatments prescribed for the child.

a. The department may delegate its authority, as custodian, to consent to routine and emergency medical care to a licensed foster parent or approved kinship foster caregiver.

b. Routine medical care includes but is not limited to the following areas:

(1) Preventive care, also known as wellness care, not including the administration of a vaccination. Parents or guardians of the child must provide consent for administration of a vaccination.

(2) Non-emergency medical care, including but not limited to a physical examination, a diagnostic laboratory test, or a medical visit for a minor illness.

(3) Routine dental and vision care, including cleanings and annual examinations.

(4) Use of necessary medication, including but not limited to antibiotics. This does not include psychotropic/mental health medications. Parents or guardians of the child must provide consent for the administration of new psychotropic/mental health medications.

c. When routine and emergency medical consent has not been delegated by the department to the approved kinship foster caregiver:

(1) Kinship foster caregivers shall contact the child's parents to engage them in the process of accessing routine medical and dental care for their child unless parental rights have been terminated.

(2) In case of an emergency or urgent situation requiring medical care and treatment of an acute illness, disease or condition of the child, when a delay or inability to access parental or department consent for medical care or treatment would endanger the health or physical well-being of the child, kinship foster caregivers can provide consent for medical care and treatment.

125.8(2) *Exemption from medical care.* Nothing in this rule shall be construed to require medical treatment or immunization for a minor child of any person who is a member of a church or religious organization that is against medical treatment for disease.

a. In such instance, an official statement from the organization and a notarized statement from the parents shall be incorporated in the record.

b. In potentially life-threatening situations, the child's care shall be referred to appropriate medical and legal authorities.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.9(237) Training and discipline of child.

125.9(1) *Methods of training and discipline.* The home study evaluation of each applicant shall include a discussion and a written assessment of the kinship foster caregivers' methods of training and discipline. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

125.9(2) *Reports of mistreatment.* Reports of mistreatment coming to the attention of the department and the caseworker for the child will be investigated by the department promptly and referred to the proper authorities when necessary.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.10(237) Emergency care and release of child.

125.10(1) *Supervision and arrangements for emergency care.* Kinship foster caregivers shall provide supervision of the child in preadoptive placement as dictated by the individual child's specific needs.

a. In case of emergency requiring the kinship foster caregiver's temporary absence from the home, arrangements shall be made with designated, responsible persons for the care of the child during the period of absence.

b. The department shall be notified of all emergency absences of the kinship foster caregivers.

125.10(2) *Release of child.* The kinship foster caregivers shall release the child only to the agency, a parent or guardian from whom the child was received for care, or the person specifically designated by the agency, parent or guardian.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.11(237) Changes in kinship foster care home. Kinship foster caregivers shall notify the department and the recruitment and retention contractor within 30 working days of:

1. Any change in the persons living in the home (except for the child placed in the home);
2. A move to a new home; or

3. Any circumstances in the home that could negatively affect the health, safety or welfare of the child in the family's care.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

441—125.12(237) Liability. Kinship foster caregivers who apply the reasonable and prudent parent standard reasonably and in good faith in regard to the child(ren) placed in their home shall have immunity from civil or criminal liability that might otherwise be incurred or imposed. This rule shall not remove or limit any existing liability protection afforded under any other law.

[**ARC 0110D**, IAB 3/4/26, effective 5/1/26]

These rules are intended to implement Iowa Code chapter 237 and section 234.40.

[Filed ARC 0110D (Notice ARC 9846C, IAB 12/24/25), IAB 3/4/26, effective 5/1/26]

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

CHAPTERS 126 to 129
Reserved

TITLE XIII
SERVICE ADMINISTRATION

CHAPTER 130
GENERAL PROVISIONS

[Prior to 7/1/83, Social Services[770] Ch 130]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/32

441—130.1(234) Definitions.

"Family" includes the following members:

1. Legal spouses (including common law) who reside in the same household.
2. Natural, adoptive, or stepmother or stepfather and children who reside in the same household.
3. An individual or a child who lives alone or who resides with a person, or persons, not legally responsible for the child's support.

"Family-centered services" means services provided by the department pursuant to 441—Chapter 172.

"Temporary absence" means:

a. A medical absence anticipated to be less than three months;

b. An absence for the purpose of education or employment; or

c. When a family member is absent and intends to return home within three months.

[**ARC 0770D**, IAB 11/25/26, effective 1/1/27]

441—130.2(234) Application.

130.2(1) Application for social services shall be made at any department office on forms prescribed by the department. Application for services shall be made on an Application for All Social Services form.

130.2(2) The application may be filed by the applicant; the applicant's authorized representative; or, where the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

130.2(3) The date of application is the date a signed application form is received in the department office.

130.2(4) The application will be approved or denied within 30 days from the date of application and the applicant notified of the decision. The decision will be mailed or given to the applicant on the date the determination is made, except that for services ordered by the court, the court order provided by the court and the case permanency plan provided by the department shall serve as notification. When individual case management services are being provided, the application will be approved or denied no later than the date that the department service manager, who is part of the interdisciplinary team, signs the individual program plan.

130.2(5) Eligibility will be redetermined in the same manner as an application at least every six months for family-centered services. For all other services, eligibility will be redetermined in the same manner as an application at least every 12 months.

[**ARC 0770D**, IAB 11/25/26, effective 1/1/27]

441—130.3(234) Eligibility.

130.3(1) Eligibility factors for services available through the department are individual need for a service and family income except when services are provided without regard to income or when services are directed in a court order.

a. Individual need is established when the service to be provided is directed at and will facilitate an individual in reaching or maintaining one of the goals and objectives in 130.6(1). Except when the court establishes need, the department will establish individual need in accordance with each individual service's rules. The department will determine the number of units to be provided.

b. The block grant service to be provided will be contained in the pre-expenditure report and listed for the specific district and county. Service available through the department and funded by resources other than the social service block grant is identified in rules for that specific service.

c. Service will be provided only when funds are available for service delivery.

d. Persons are financially eligible for services when they are in one of the following categories:

(1) Income maintenance status. They are recipients of the family investment program (FIP), those whose income was taken into account in determining the needs of FIP recipients, recipients of supplemental security income or state supplementary assistance, or those in the 300 percent group as defined in 441—subrule 75.6(4).

(2) Income eligible status. The monthly gross income is based on family size. Family size income levels are found on the department's website.

e. Certain services are provided without regard to income, which means family income is not considered in determining eligibility. The services provided without regard to income are information and referral, child protective assessment, child abuse treatment, child abuse prevention services, including protective child care services, family-centered services, dependent adult abuse evaluation, dependent adult abuse treatment, dependent adult abuse prevention services, and purchased adoption services to individuals and families referred by the department.

f. In certain cases, the department will provide services directed in a court order.

130.3(2) To be eligible for services, the person must be living in the state of Iowa. Living in the state includes those persons living in Iowa for a temporary period, other than for the purpose of vacation.

130.3(3) In determining gross income, all income received by an individual from sources identified by the U.S. Census Bureau in computing median income is considered and includes money wages or salary, net income from nonfarm self-employment, net income from farm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, worker's compensation, alimony, child support, and veterans pensions. Excluded from the computation of monthly gross income are the following:

a. Per capita payments to or funds held in trust for any individual in satisfaction of a judgment of the Indian claims commission or the court of claims.

b. Payments made pursuant to the Alaska Claims Settlement Act as amended to August 1, 2026, to the extent such payments are exempt from taxation under Section 21(a) of the Act as amended to August 1, 2026.

c. Money received from the sale of property unless the person was engaged in the business of selling such property.

d. Withdrawals of bank deposits.

e. Money borrowed.

f. Tax refunds.

g. Gifts.

h. Lump sum inheritances or insurance payments or settlements.

i. Capital gains.

j. The value of USDA-donated foods.

k. The value of supplemental food assistance under the Child Nutrition Act of 1966 as amended to August 1, 2026, and the special food program for children under the National School Lunch Act as amended to August 1, 2026.

l. Earnings of a child 14 years of age or under.

m. Loans and grants obtained and used under conditions that preclude their use for current living expenses.

n. Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act as amended to August 1, 2026.

o. Home produce utilized for household consumption.

p. Stipends received by persons for participating in the foster grandparent program.

q. The first $65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

r. Payments from the low-income home energy assistance program (LIHEAP).

s. In determining eligibility for purchase of local services, one-third of the income of a disabled survivor who is a recipient of child's insurance benefits under the federal old-age, survivors, and disability

insurance program established under Title II of the federal Social Security Act as amended to August 1, 2026.

t. In determining eligibility for purchase of local services, one-third of the income of a person who receives social security permanent disability benefits.

u. Agent Orange settlement payments.

v. Rent reimbursement provided under Iowa Code chapter 425.

w. Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

130.3(4) Temporary absence. The composition of the family group does not change when one, or more, of the group members is temporarily absent from the household.

[**ARC 0770D**, IAB 11/25/26, effective 1/1/27]

441—130.4(234) Adverse service actions.

130.4(1) *Denial.* Services will be denied when it is determined by the department that:

a. The client is not in need of service;

b. The client is not financially eligible;

c. The service to be provided is not in the Social Services Block Grant Pre-Expenditure Report;

d. There is another community resource available to provide the service or a similar service free of charge to the client that will meet the client's needs;

e. In cases other than protective service investigation, the client, parent, or representative refuses to sign the application form;

f. The service for which the client is eligible is currently not available; or

g. Funding is not available to provide the service.

130.4(2) *Termination.* A particular service may be terminated when the department determines any one or combination of the following factors:

a. The specific need to attain the goals and objectives to which the service was directed has been achieved;

b. After repeated assessment, it is evident that the family or individual is unable to achieve or maintain the goals set forth in the individual client service plan;

c. After repeated efforts, it is evident that the family or individual is unwilling to accept further service;

d. The client's income or resources exceed the financial guidelines, or the client no longer meets other eligibility criteria established by the department for the service;

e. The service is no longer offered or available from the department;

f. Another community resource is available to provide the service or a similar service free of charge to the client that will meet the client's needs;

g. The client refuses to allow documentation of eligibility as to need, income, and resources; or

h. Funding is not available to provide the service.

130.4(3) *Reduction.* A particular service may be reduced when the department determines one of the following:

a. Continued provision of service at its current level is not necessary. The department will determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal.

b. Another community resource is available to provide the same or similar service to the client at no financial cost to the client, that will meet the client's needs.

c. Funding is not available to continue the service at the current level. The client will be reassessed to determine the level of service to be provided.

130.4(4) *Pending changes.* The department will endeavor to make clients aware of pending changes in services to be provided by social services block grant from one program year to the next, particularly for those services that will no longer be available. This requirement also applies to time-limited services.

130.4(5) *Notice and appeal.* Notice of adverse service actions will be issued in accordance with 441—Chapter 16 and may be appealed pursuant to 441—Chapter 2506.

[**ARC 0770D**, IAB 11/25/26, effective 1/1/27]

441—130.5(234) Social casework. For each active service case, when service is provided directly, purchased, or by a combination of methods, the department will:

130.5(1) Determine eligibility.

130.5(2) Ensure there is a department case plan for each individual or family based on assessment of strengths and needs. The department will furnish appropriate sections of the initial plan and of all updated department case plans to the provider agency when services are purchased for an individual. When individual case management services are being provided, the individual case management services provider shall distribute the case plans.

130.5(3) Refer the client to other agencies through proper channels and coordinate all people involved in the case. When individual case management services are being provided, the individual case management services provider shall be responsible for making referrals and coordinating workers as specified in the individual program plan.

130.5(4) Enter information to the service reporting system.

130.5(5) Monitor the case to ensure that eligibility continues, services are received, plans are adjusted as needed, services reporting system reporting is correct, and the case is canceled when appropriate, according to these rules.

130.5(6) Ensure that services are unavailable elsewhere without cost to the client.

[**ARC 0770D**, IAB 11/25/26, effective 1/1/27]

441—130.6(234) Case plan. The department will develop a case plan with or on behalf of persons approved to receive services. However, a case plan is not required (1) for child or adult protective assessment, (2) for foster care cases in which the department does not have custody, guardianship or a voluntary placement agreement, or (3) when child care is the only service. A case plan will be developed with or on behalf of every other person approved to receive services unless the person has a case manager as specified in 441—Chapter 24. When department services are provided before an individual program plan in compliance with 441—Chapter 24 is approved, a department case plan will be developed according to the requirements of this rule. When individual case management services are being provided, the rules in 441—Chapter 24 on time limits, plan format and on who develops the plan will apply for adults and for children whose services are not under court jurisdiction. The department will determine eligibility for those services provided by the department; however, a separate department case plan need not be developed. If the individual program plan does not include sufficient information to meet department service requirements or the requirements in this chapter, the person providing department social casework will complete either a case plan or addendum and coordinate distribution to the persons who receive the individual program plan with the case manager.

The case plan will become part of the client's case record. The client shall participate in the development of this plan to the extent possible. The case plan will be consistent with other service or program plans. A copy of the case plan will be provided to the client or, when indicated, to the parent or representative of the client. For adult services, the case plan will be recorded using an individual service plan. For children's services, the case plan will be known as the case permanency plan and will be prepared using a family case plan.

130.6(1) Services will be directed toward the social services block grant goals of:

a. Achieving or maintaining self-support to prevent, reduce or eliminate dependency.

b. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency.

c. Preventing or remedying neglect, abuse or exploitation of children or adults unable to protect their own interest or preserving, rehabilitating or reuniting families.

d. Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care.

e. Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

130.6(2) The recorded case plan will contain but not be limited to the following:

a. The goal and objective to which the plan is directed, stated in a clear manner indicating the specific services required to achieve or maintain the goals to meet the needs of the particular client.

b. Activities of clients and others involved in the plan related to specific services. These will be measurable and have time frames for completion.

c. A summary of all pertinent information relating to the client and the client's situation relative to need, containing but not limited to the following:

(1) Emotional behavior.

(2) Social aspects.

(3) Historical perspective.

(4) Reasons for success or lack of success.

(5) Safety-related information indicating whether a child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse. The safety-related information will be withheld only if ordered by the court or if the department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

(6) An assessment of whether continued breastfeeding by a child's mother is in the best interest of the child and a plan to support the mother's breastfeeding efforts, if appropriate.

d. Information on case entries that will substantiate the client's eligibility for service.

e. A target date for reevaluation of the case plan based on assessment of need that shall not exceed six months.

f. A review of financial eligibility in accordance with 130.2(5).

g. The reason for termination or reduction of any or all services.

130.6(3) The case plan will be developed and filed in the case record as follows:

a. In child welfare cases, the case plan will be developed in partnership with the child, the family, and the caregiver.

(1) The recommendations from the child protective assessment and the safety plan developed with the family will be considered an initial case plan.

(2) A case permanency plan that meets the requirements of Iowa Code section 232.2 will be filed within 60 days from the date the child enters foster care or the date the department opens a child welfare service case, whichever occurs first.

b. For all other cases, the case plan shall be developed before services begin unless there is an unanticipated provision of service for the protection and well-being of a client. In that case, the case plan will be filed within 45 days from the date that services begin.

130.6(4) The reevaluation of the case plan will include all components listed under 130.6(2) and will be filed at least every six months or more often when there are significant changes, when required by the court, or when required according to the rules of the service.

130.6(5) The case plan may be amended between evaluation periods. Participants in the plan will receive a copy of the amendment.

[**ARC 0770D**, IAB 11/25/26, effective 1/1/27]

441—130.7(234) Entitlement. There is no automatic right to ongoing service in any service category from one fiscal year to the next.

[**ARC 0770D**, IAB 11/25/26, effective 1/1/27]

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 131
SOCIAL CASEWORK

[Prior to 7/1/83, Social Services[770] Ch 159]
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[Prior to 2/11/87, Human Services[498]]
Rescinded **ARC 0458D**, IAB 8/5/26, effective 10/1/26

CHAPTER 132
STATE PAYMENT PROGRAM FOR SERVICES TO ADULTS

Rescinded IAB 7/8/92, effective 7/1/92

CHAPTER 133
IV-A EMERGENCY ASSISTANCE PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/31

441—133.1(235) Definitions.

"Child" means a person under 18 years of age or a person 18 or 19 years of age who meets any of the following conditions:

1. Is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma,
2. Is attending an instructional program leading to a high school equivalency diploma, or
3. Has been identified by the director of special education of an area education agency as a child requiring special education as defined in Iowa Code section 256B.2(1)*"a."*

A person over 18 years of age who has received a high school diploma or a high school equivalency diploma is not a child within this definition.

"Emergency assistance" means any one or more of the following services provided in response to a IV-A emergency assistance application:

1. Family-centered services as set forth in 441—Chapter 172.
2. Shelter care as set forth in 441—Chapters 156 and 202, except for placements of less than 48 hours.
3. Protective child care as set forth in 441—Chapter 170.

"Family" includes the following members:

1. Legal spouses (including common-law) who reside in the same household.
2. Natural, adoptive, or stepmother or stepfather, and children who reside in the same household.
3. An individual or child who lives alone or who resides with a person, or persons, not legally responsible for the child's support.

[**ARC 0500D**, IAB 8/19/26, effective 10/1/26]

441—133.2(235) Application. An application for emergency assistance shall be made on a form prescribed by the department. An application shall be completed any time a decision is made to provide emergency assistance or when an adult family member requests emergency assistance on behalf of a child.

133.2(1) The application shall be filed by a parent, except where both parents are absent or unwilling to apply on behalf of a child who meets all other eligibility conditions, in which case another adult member of the family with whom the child resides or has resided within the past six months acting on behalf of the child may file the application.

133.2(2) If the application is made on behalf of a child for whom the department has legal custody, the department may sign the application on behalf of the child.

[**ARC 0500D**, IAB 8/19/26, effective 10/1/26]

441—133.3(235) Eligibility. To be eligible for emergency assistance, the family shall meet all of the following criteria.

133.3(1) *Existence of an emergency.* An emergency situation shall exist. An emergency exists when one of the following situations exists:

a. Abuse, neglect, or abandonment of a child, or risk of same.

b. Children are in imminent danger where continued presence in the home is not in the best interest of the child.

c. Children have been removed from the home or are at risk of removal from the home because of abuse; neglect, which may include homelessness; or inability of parents to provide needed care or treatment or to control the behavior of the child.

133.3(2) *No refusal to accept employment or training.* The emergency situation did not arise out of an applicant's or applicant's family's refusal without good cause to accept employment or training for employment within 30 days of the date of the application.

133.3(3) *Residence.* The child is living, or within six months prior to the month in which assistance is requested has been living, with a specified relative. "Relative" includes people related by blood, marriage, or adoption. The 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 one of the following even though the marriage is terminated by death or divorce:

a. Father—adoptive father.

b. Mother—adoptive mother.

c. Grandfather—grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather—adoptive grandfather.

d. Grandmother—grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother—adoptive grandmother.

e. Great-grandfather—great-great-grandfather.

f. Great-grandmother—great-great-grandmother.

g. Stepfather, but not his parents.

h. Stepmother, but not her parents.

i. Brother—brother-of-half-blood—stepbrother—brother-in-law—adoptive brother.

j. Sister—sister-of-half-blood—stepsister—sister-in-law—adoptive sister.

k. Uncle—aunt, of whole or half blood.

l. Uncle-in-law—aunt-in-law.

m. Great uncle—great-great-uncle.

n. Great aunt—great-great-aunt.

o. First cousins—nephews—nieces.

p. Second cousins, meaning the son or daughter of one's parent's first cousin.

133.3(4) *Service need.* The applicant must demonstrate a need for one or more of the emergency assistance services as follows:

a. Family-centered services as established in 441—Chapter 172.

b. Shelter care as established in rule 441—202.2(234).

c. Protective child care as established in 441—subparagraph 170.2(2)*"b"*(3).

133.3(5) *Receipt of assistance.* An application for IV-A emergency assistance was not previously approved within 12 months of the current application for IV-A emergency assistance.

133.3(6) *Financial eligibility.* The applicant family:

a. Is receiving family investment program (FIP), supplemental security income (SSI), Supplemental Nutrition Assistance Program (SNAP) benefits, or Medicaid in the month of the application, or

b. Does not have money to provide needed emergency care or services as evidenced by the applicant family's income not exceeding 800 percent of the poverty guidelines established by the federal Office of Management and Budget.

[**ARC 0500D**, IAB 8/19/26, effective 10/1/26]

441—133.4(235) Method of service provision. Services shall be provided through the department or through purchase of service agreements with providers that are approved by the department as qualified to provide specified services and have a current contract with the department to provide services.

[**ARC 0500D**, IAB 8/19/26, effective 10/1/26]

441—133.5(235) Duration of services. Services to families and children provided through the emergency assistance program as a result of a single application may be provided for either a period not to exceed 12 months or until there is no longer a need for services according to eligibility criteria for the specified services, whichever occurs first.

[**ARC 0500D**, IAB 8/19/26, effective 10/1/26]

441—133.6(235) Discontinuance of the program. The program will be discontinued when federal funds have been exhausted.

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CHAPTERS 134 to 141
Reserved

CHAPTER 142
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 142]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 9/1/31

441—142.1(232) Compact agreement. As a member of the interstate compact on the placement of children, the department will cooperate on interstate aspects of placements preliminary to possible adoptions, placements in foster care where no adoption is contemplated, placements with any parent or relative, and institutional placements of adjudicated children in need of assistance needing special services or programs not available within the state. Any public or private agency instrumental in placement of a child in Iowa or from Iowa and in such public or private agency's custody will go through the interstate compact on placement of children.
[**ARC 0449D**, IAB 7/22/26, effective 9/1/26]

441—142.2(232) Compact administrator.

142.2(1) The compact administrator may appoint up to three deputy compact administrators to serve as active members of the association of administrators of the interstate compact on the placement of children and who shall be responsible for day-to-day operation of the interstate compact.

142.2(2) The compact administrator shall be responsible for the administration of the compact between the compact administrator's state and other contracting states.
[**ARC 0449D**, IAB 7/22/26, effective 9/1/26]

441—142.3(232) Article III(a) procedures.

142.3(1) All intended placements in Iowa or from Iowa coming under the purview of this compact shall be referred to the department.

142.3(2) All persons involved in the placement of a child into Iowa or from Iowa into another state shall meet all the placement requirements of the receiving state prior to the actual placement.

142.3(3) Supervision of placements made by persons or agencies outside of Iowa shall be provided by a licensed Iowa agency, the department, or an Iowa-certified adoption investigator. Exempted from this provision are:

a. Any agency licensed as a child-placing agency in another state that has its principal place of business in a county directly adjacent to an Iowa border may practice in the Iowa counties contiguous to the out-of-state county.

b. Placement in a facility for treatment that is licensed by the department unless the department specifies that the supervision must be provided by the department for all placements in any particular facility.
[**ARC 0449D**, IAB 7/22/26, effective 9/1/26]

441—142.4(232) Article III(c). A child may be placed in Iowa preliminary to adoption only when there has been a preplacement investigation by an authorized person or agency in Iowa, such investigation has been made available to the department, the investigation has been made within the past year, and the sending state intending to place the child has been notified that the home has been approved for an adoptive placement in Iowa.
[**ARC 0449D**, IAB 7/22/26, effective 9/1/26]

441—142.5(232) Article V(c). For the purposes of article V(c), "sending state" means "sending agency."
[**ARC 0449D**, IAB 7/22/26, effective 9/1/26]

441—142.6(232) Article VIII(a). For the purpose of article VIII(a), "relative" means stepparent, grandparent, adult brother or sister, or adult uncle or aunt, and "guardian" means any guardian other than that appointed as preliminary to adoption.
[**ARC 0449D**, IAB 7/22/26, effective 9/1/26]

441—142.7(232) Applicability. The requirements of this compact shall be in effect for all placements into Iowa from any state, territory or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico and, with the consent of Congress, the government of Canada and any province thereof, or from Iowa to any state, territory or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico and, with the consent of Congress, the government of Canada and any province thereof.

[**ARC 0449D**, IAB 7/22/26, effective 9/1/26]

441—142.8(232) NEICE database.

142.8(1) *Definitions.* For the purpose of this chapter, unless the context otherwise requires:

"National Electronic Interstate Compact Enterprise system" or *"NEICE system"* means the national electronic web-based system for administration of the interstate compact on the placement of children made available to states by the American Public Human Services Association through its affiliate, the Association of Administrators of the Interstate Compact on the Placement of Children.

"Security requirements" means all policies or system security guidance established by the department and the department of management related to the use of external computer systems for the storage of personally identifiable data elements of applicants for and recipients of department services. Security requirements as defined herein include but are not necessarily limited to completion by the vendor of the then-current cybersecurity framework made available by the National Institute of Standards and Technology, department confirmation that the system has passed the cybersecurity framework analysis, completion by the vendor of an information security risk assessment acceptable to the department, performance by the vendor of a system penetration test acceptable to the department, and an application scan for vulnerabilities, as well as remediation of any vulnerabilities identified.

142.8(2) *Department obligation to provide data to the NEICE system.*

a. At all times that the NEICE system meets security requirements, the department will place in the system all data elements and information that the system is configured to accept concerning children subject to the interstate compact.

b. Prior to placing personally identifiable data elements in the NEICE system, the department will confirm that the NEICE system complies with all security requirements. If at any time after placement of personally identifiable data in the NEICE system the department determines that the NEICE system fails to meet all security requirements or that personally identifiable data placed in the system by the department has been used or disclosed inappropriately, the department may cease using the NEICE system and may demand that all data provided by the department be removed from the system.

[**ARC 0449D**, IAB 7/22/26, effective 9/1/26]

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CHAPTER 143
INTERSTATE COMPACT FOR JUVENILES
[Prior to 7/1/83, Social Services[770] Ch 143]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 9/1/31

441—143.1(232) Compact agreement. As a member of the interstate compact for juveniles, Iowa is in a contractual agreement with the other 49 states, the District of Columbia or its designee, and the United States Virgin Islands, in which the department shall cooperate on interstate aspects of juvenile delinquency, and the return from one state to another of nondelinquent children who have run away from home.
[**ARC 0450D**, IAB 7/22/26, effective 9/1/26]

441—143.2(232) Compact administrator.

143.2(1) The compact administrator may appoint a deputy compact administrator to serve as an active member of the interstate commission for juveniles and who shall be responsible for day-to-day operation of the interstate compact.

143.2(2) The compact administrator shall be responsible for the administration of the compact between the compact administrator's state and other contracting states.
[**ARC 0450D**, IAB 7/22/26, effective 9/1/26]

441—143.3(232) Sending a juvenile out of Iowa under the compact.

143.3(1) Local officials requesting to transfer a juvenile to another state shall work through the office of the compact administrator. All persons using the compact shall comply with the official rules and regulations promulgated by the compact administrator under the authority of the compact.

143.3(2) Interstate Compact for Juveniles Form VI, Application for Services and Waiver, shall be signed by the juvenile and a witness, the Iowa juvenile court judge consenting to the placement in the receiving state, and the juvenile compact deputy.

143.3(3) The Application for Services and Waiver shall have the conditions of the probation or parole as granted by the court of jurisdiction attached.

143.3(4) Whenever a juvenile is accepted in another state for supervision, the Iowa sending agency shall send medical release and financial statements signed by the parents or guardian.
[**ARC 0450D**, IAB 7/22/26, effective 9/1/26]

441—143.4(232) Receiving cases in Iowa under the interstate compact.

143.4(1) The department shall accept supervision of out-of-state cases when a juvenile meets the requirements of the interstate compact.

143.4(2) The department shall exercise the same care and treatment that is given to Iowa cases to notify the sending state promptly of any violations or antisocial behavior that may occur.

143.4(3) The receiving state shall promptly upon parole or probation violation notify the sending state. Prior to making a recommendation for revocation of parole or probation, a preliminary hearing shall be held to determine if there is probable cause for revocation of parole or probation.

143.4(4) A parolee or probationer from another state held or placed in Iowa under the provisions of article I of the compact and who commits a felony while in Iowa shall be:

a. Returned to the sending state per mutual agreement; or

b. Processed according to the Iowa statutes and not returned to the sending state for violation.
[**ARC 0450D**, IAB 7/22/26, effective 9/1/26]

441—143.5(232) Runaways.

143.5(1) A runaway from Iowa or to Iowa shall be returned to the state of residence only after Interstate Commission for Juveniles Rule 6-102 as amended to August 1, 2026, setting forth the voluntary procedures, or Interstate Commission for Juveniles Rule 6-103 as amended to August 1, 2026, setting forth the involuntary procedures, has been completed by the asylum court of jurisdiction.

143.5(2) Any nondelinquent runaway from another state found in Iowa shall be held only in a nonrestrictive shelter facility until returned to the state of legal residence.

143.5(3) Any nondelinquent runaway from another state found in Iowa may be held in a nonrestrictive shelter facility beyond 48 hours on issuance of a court order to permit arrangements for return to the home state or to permit the demanding state opportunity for issuance of a requisition under Interstate Commission for Juveniles Rule 6-103 as amended to August 1, 2026.

143.5(4) Any runaway from another state who is charged with a felony under Iowa Code chapter 232 may either be held in a secure setting until returned to the state of legal residence or be adjudicated delinquent under Iowa Code chapter 232, placed on probation, and returned to the state of legal residence under article I of the compact.

143.5(5) Any adjudicated delinquent who has escaped or absconded from another state and has been apprehended as a nondelinquent runaway in Iowa may be held in a secure setting awaiting return to the demanding state under Interstate Commission for Juveniles Rules 6-102 and 6-103, both as amended to August 1, 2026.

143.5(6) The department shall pay for the return to Iowa of any runaway, escapee, or absconder for whom the department has, at the time the juvenile left the state, legal custody or guardianship responsibility. The responsibility for the payment for the return of a runaway, escapee, or absconder not under custody or guardianship of the department shall be that of the juvenile court having legal jurisdiction of the juvenile.

[**ARC 0450D**, IAB 7/22/26, effective 9/1/26]

These rules are intended to implement Iowa Code section 232.173.

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CHAPTERS 144 to 149
Reserved

TITLE XIV
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150
PURCHASE OF SERVICE
[Prior to 7/1/83, Social Services[770] Ch 145]
[Previously appeared as Ch 145—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]
Rescinded **ARC 2885C**, IAB 1/4/17, effective 3/1/17

CHAPTER 151
JUVENILE COURT-ORDERED SERVICES

[Prior to 7/1/83, Social Services[770] Ch 141]
[770—Ch 141 renumbered as 498—Ch 209, IAB 2/29/84]
[Agency number changed from [498] to [441] IAB 2/11/87]
[Prior to 7/26/89, 441—Ch 209]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/31

441—151.1(232) Definitions.

"Child" means a person under 18 years of age.

"Child welfare services" means services to maintain a child's connection to the child's family and community, to promote reunification or other permanent placement, and to facilitate a child's transition to adulthood.

"Court-ordered services" means the defined or specific care and treatment that are authorized by the court for an eligible child or the parent of an eligible child and for which no other payment source is available to cover the cost.

"Eligible child" means a child supervised by the department for whom the juvenile court judge has provided an order for a service funded under court-ordered services.

"Provider" means a public agency, including a school district or government unit, or a private agency, organization or eligible individual authorized to do business in the state. The provider is also known as the claimant.

"Service area" means one of the five geographic areas designated by the department for the provision of family well-being and protection services.

[**ARC 0176D**, IAB 4/1/26, effective 6/1/26]

441—151.2(232) Administration of funds for court-ordered services. Pursuant to the authority granted in Iowa Code chapters 7E, 8, 232, and 602 and the annual appropriations Acts, the executive branch, represented by the department, and the judicial branch, represented by the juvenile court judges, are each charged with specific responsibilities for funding, administering, and providing court-ordered services.

151.2(1) *Allocations for court-ordered services.* Court-ordered services are funded by an appropriation made to the department.

151.2(2) *Court order requirement.* Upon the request of any party, the court may authorize the use of court-ordered services for child welfare services as defined in subrules 151.4(1) and 151.4(2).

151.2(3) *Application for funds.* The department will complete an application for the use of court-ordered service funds upon receiving the order.

151.2(4) *Availability of funds.* The department will have the opportunity to establish the availability of funds once an authorization for court-ordered services is received from the court.

151.2(5) *Monitoring of funds.* The department will monitor and communicate the availability of the court-ordered services funds to ensure that funds are available throughout the state fiscal year.

151.2(6) *Emergency or after-hours situations.* Any services that are provided without the signed approval of the department's approved administrator may be denied payment, unless there is an emergency or after-hours situation and no other provision exists for handling emergency or after-hours situations or transports.

151.2(7) *Transfer of funds to a decategorization governance board for administration.* Funds allocated to the department for court-ordered services may be transferred to a decategorization governance board for administration.

151.2(8) *Billing and payment.* The department will ensure that billing and payment are in compliance with the requirements of the accounting policies and procedures manual of the department of administrative services, state accounting enterprise as amended to August 1, 2025. A claim that meets the requirements of this chapter becomes a state liability on the date of a claim's accrual. The date of a claim's accrual is the date the service was provided, the end of the agreed-upon billing interval specified in the contract, or the date of a determination of liability for the claim.

[**ARC 0176D**, IAB 4/1/26, effective 6/1/26]

441—151.3(232) Use of other funding sources. The department, in cooperation with juvenile court judges, will ensure that the funds allocated for court-ordered services are spent only after all other reasonable actions have been taken to use other funding sources. Services are not eligible for reimbursement when another payment source is available.

151.3(1) The department will maximize the use of funds that may be available from the Medicaid program, including coverage for early and periodic screening, diagnosis, and treatment and for psychiatric medical institutions for children (PMIC), before requesting assistance through the court-ordered services fund. However, medical cost sharing for the one-time payment per court order of a deductible amount or a coinsurance amount for treatment specified in a court order is an allowable expense that may be paid through the court-ordered services fund when insurance or Medicaid is then available to pay the remainder of the cost.

151.3(2) The department may recover payments from any third-party insurance carrier that is liable for coverage of the services, including health insurance coverage. The department may submit claims to third-party insurance carriers liable for coverage of the services before the claims are submitted for payment through the court-ordered services fund.

151.3(3) The date of a medical claim's accrual for reimbursement through court-ordered services is the date the claim becomes a state liability. For example, a claim becomes a state liability on:

a. The date of a court order for a contested claim; or

b. The date of a determination by Medicaid or private insurance that Medicaid or private insurance denies partial or full payment for care and treatment for which an application has been made.

151.3(4) If eligible for reimbursement through the court-ordered services fund, medical claims that are submitted to, but are denied by, Medicaid or private insurance will be paid at a rate not to exceed the rate set by Medicaid.

151.3(5) Allowable rates not available. When the department has been unable to establish an allowable rate of reimbursement for a service or a provider, the department's approved administrator or designee will negotiate a reimbursement rate with the provider to obtain the service at a reasonable cost based on available community or statewide rates.

[**ARC 0176D**, IAB 4/1/26, effective 6/1/26]

441—151.4(232) Expenses. The following lists of expenses that are eligible for reimbursement from the court-ordered services fund are intended to be exhaustive. Billings for services not listed in subrule 151.4(1) cannot be paid except as provided in subrule 151.4(2).

151.4(1) *Expenses to be reimbursed.* The expenses for which reimbursement will be made include:

a. Expenses, other than salary, incurred by a person ordered by the court, other than a juvenile court officer, in transporting a child to or from a place designated by the court, including mileage, lodging and meals.

b. The expense of care or treatment ordered by the court whenever the minor is placed by the court with someone other than the parents; or a minor is given a physical or mental examination or treatment under order of the court; or, upon certification by the department, a minor is given physical or mental examinations or treatment with the consent of the parent, guardian or legal custodian relating to a child abuse investigation and no provision is otherwise made by the law for payment for the care, examination, or treatment of the minor. Care and treatment expenses for which no other provision for payment is made by law that will be reimbursable include court-ordered:

(1) Individual services for the child separate from a family's treatment plan.

(2) Diagnosis and evaluation on an outpatient basis unless the diagnosis and evaluation is provided by a person or agency with a contract with the department for the service for which the child is eligible.

(3) An evaluation of a child in a residential facility.

(4) Inpatient (hospital) evaluation of a child previous to disposition.

(5) Medical treatment for a child. This includes medical treatment while in detention in a facility used for detention when the medical treatment is court-ordered.

(6) Drug treatment, testing and care for a child.

(7) Intensive in-home supervision and monitoring and alternatives to shelter care unless a person or agency that has a contract with the department provides the service for which the child is eligible.

(8) Evaluation of parents pursuant to an adjudication unless the diagnosis and evaluation is provided by a person or agency with a contract with the department for that service for which the child is eligible.

(9) Physical or mental examinations ordered pursuant to Iowa Code section 232.49 or 232.98 or those eligible for payment pursuant to Iowa Code chapter 249A.

(10) Services ordered under family in need of assistance proceedings unless a person or agency with a contract with the department provides the service for which the child is eligible.

(11) Expenses for all educational testing or programming for children, not weighted as special education students, who attend an on-campus school in an out-of-state facility.

(12) Expenses for educational testing or programs related to a high school equivalency diploma or for credit hours, when the expenses are not required to be paid by the state.

(13) Medical cost sharing for payment of a deductible amount or a coinsurance amount when Medicaid or private insurance is then available to pay the remainder of the cost.

151.4(2) *Expenses not listed.* Expenses not covered in subrule 151.4(1) will be eligible for reimbursement from court-ordered service funds only under the following circumstances:

a. The expense is for a child welfare service;

b. The expense is authorized by the court;

c. The reimbursement is not in conflict with current law or administrative rule, and

d. No alternative funding sources are available to pay for the service.

[**ARC 0176D**, IAB 4/1/26, effective 6/1/26]

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CHAPTER 152
FOSTER CARE CONTRACTING

Chapter rescission date pursuant to Iowa Code section 17A.7: 12/1/31

441—152.1(234) Definitions.

"Affiliates" means persons having a relationship such that any one of them directly or indirectly controls or has the power to control another.

"Authorized representative" means that person appointed to carry out audit procedures, including an assigned auditor, fiscal consultant, or agent contracted for a specific audit or audit procedure.

"Child" means the same as defined in Iowa Code section 234.1.

"Claim" means each record the department receives that tells the amount of requested payment and the service rendered by a provider to a child and family.

"Client" means a child who has been found to be eligible for foster care services through the department.

"Confidence level" means the probability that an overpayment or underpayment rate determined from a random sample of charges is less than or equal to the rate that exists in the sample from which the sample was drawn.

"Contract" means a formal written agreement between the department and a provider of foster care services.

"Extrapolation" means using sample data meeting the confidence level requirement to estimate the total dollars of overpayment or underpayment.

"Family," for purposes of child welfare service delivery, includes the following:

1. The natural or adoptive parents, stepparents, domestic partner of the natural or adoptive parent, and children who reside in the same household.
2. A child who lives with an adult related to the child within the fourth degree of consanguinity and the adult relatives within the fourth degree of consanguinity in the child's household who are responsible for the child's supervision. Relatives within the fourth degree of consanguinity include full or half-siblings, aunts, uncles, great-aunts, great-uncles, nieces, great-nieces, nephews, great-nephews, grandparents, great-grandparents, great-great-grandparents, and first cousins.
3. A child who lives alone or who resides with a person or persons not legally responsible for the child's support.

"Fiscal record" means a tangible and legible history that documents financial and statistical records.

"Juvenile court officer" means a person appointed as a juvenile court officer or chief juvenile court officer under Iowa Code chapter 602.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to foster care services and results in a payment greater than that to which the provider is entitled.

"Probation" means a specified period of conditional participation in the provision of foster care services.

"Provider" means the entity that has executed a contract with the department to provide services.

"Random sample" means a systematic (or every "nth" unit) sample for which each item in the sample has an equal probability of being selected.

"Referral worker" means the department worker or juvenile court officer who refers the case to a provider and who is responsible for carrying out the follow-up activities of determining client eligibility and ensuring that the service authorization is completed.

"Service authorization" means the process of determining service necessity and the level of care and number of units of service to be provided to a child.

"Service record" means an individual, tangible, and legible file that records service-related activities set forth in subrule 152.2(4).

"Site" means each licensed location of the foster care provider.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible recipients according to the laws and rules applicable to the foster care services program and to which the provider is entitled.

"Unit of service" means one day for group care and child welfare emergency services shelter.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted claims for purposes of offsetting overpayments previously made to the provider.

[**ARC 0670D**, IAB 10/14/26, effective 12/1/26]

441—152.2(234) Conditions of participation.

152.2(1) *Provider licensure.* A provider facility shall obtain licensure prior to accepting placements from the department.

152.2(2) *Provider staffing.* At a minimum, all providers shall meet all licensure requirements for staff qualifications, training, and number of staff pursuant to 441—Chapter 105, 108, or 114.

152.2(3) *Provider charges.* A provider cannot charge department clients more than it receives for the same foster care services provided to nondepartment clients. The provider shall agree not to require any fee from department clients unless a fee is required by the department and is consistent with federal regulation and state policy.

152.2(4) *Maintenance of service records.* A provider shall maintain complete and legible records as required in this subrule.

a. For foster group care and shelter care, the provider shall establish and maintain confidential, individual service records for each client receiving foster care services. The service records must adequately support the provision of child welfare services and group care maintenance. The service record shall include, at a minimum, those items identified in rule 441—114.11(237) and 441—Chapter 105 and shall also include all of the following:

(1) Additional reports, if requested by the referral worker.

(2) Referral and Authorization Form.

(3) Daily documentation of billed per diem services. The documentation shall include:

1. The child's first and last name;
2. The month, day, and year service was provided;
3. The first and last names of the persons who or organizations that provided the service;
4. A clear description of the specific service rendered, including interventions, actions, and activities performed that support the provision of child welfare services.

(4) Notes, which shall be entered no less than every seven calendar days, indicating the child's general progress in regard to the child's care plan.

(5) Any problem areas or unusual behavior for the child.

b. For supervised apartment living, the provider shall establish and maintain confidential, individual service records for each client receiving supervised apartment living services.

c. Failure to maintain records or failure to make records available to the department or to its authorized representatives upon request may result in a notice of violation and recoupment of payments.

152.2(5) *Maintenance of financial and statistical records.* The provider shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department. The records shall be available for review at any time during normal business hours by department personnel, the department's fiscal consultant, and state or federal audit personnel.

a. At a minimum, financial and statistical records shall include all revenue and expenses supported by a provider's general ledger and documentation on file in the provider's office. These records include, at a minimum:

(1) Payroll information.

(2) Capital asset schedules.

(3) All canceled checks, deposit slips, and invoices (paid and unpaid).

(4) Audit reports (if any).

(5) The board of directors' minutes (if applicable).

(6) Loan agreements and other contracts.

(7) Reviewable, legible census reports and documentation of units of service provided to department clients that identify the individual client and are kept on a daily basis and summarized in a monthly report.

(8) For nondepartment clients, sufficient documentation of utilization to establish a complete unit of service count.

b. The provider shall maintain a list of all staff and supervisors providing foster care services and their qualifications for each program.

c. When a provider has an independent audit conducted, a firm not related to the provider shall conduct the audit. The provider shall submit a copy of the independent audit report to the department within 30 days of receipt of the report.

152.2(6) *Cost report.* Providers shall complete the Combined Cost Report Form as required by contract.

a. Due date. The cost report shall be submitted to the department no later than three months after the close of the provider's established fiscal year. The provider may request a one-month extension.

b. Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

c. County reimbursement for child welfare services shelter costs. If a shelter care provider's actual and allowable costs as set forth in 441—Chapter 156 for a child's shelter care placement exceed the amount the department is authorized to pay and the provider is reimbursed by the child's county of legal settlement for the difference between actual and allowable costs and the amount reimbursed by the department, the amount paid by the county cannot be included by the department in its reimbursement rate determination, as long as the amount paid is not greater than the provider's actual and allowable costs or the statewide average of actual and allowable costs as identified in annual appropriations, whichever is less.

[**ARC 0670D**, IAB 10/14/26, effective 12/1/26]

441—152.3(234) Provider reviews. The department may, at its discretion, review any provider at any time. Records generated and maintained by the department or its fiscal agent may be used by reviewers and in all proceedings of the department.

152.3(1) *Review of provider records.* The department has the authority to conduct a scheduled or unannounced visit to evaluate the adequacy of service records in compliance with the policies and procedures for foster care services.

152.3(2) *Purpose.* Upon proper identification, authorized representatives of the department have the right to review the service and fiscal records of the provider to determine whether:

a. The department has accurately paid claims for services.

b. The provider has furnished the services.

c. The provider has retained service records and fiscal records that substantiate claims submitted for payment during the review period.

d. Expenses reported to the department have been handled as required under subrule 152.2(6).

152.3(3) *Method.* The department will select the appropriate method of conducting a review and will protect the confidential nature of the records being reviewed. The provider may be required to furnish records to the department. The provider may select the method of delivering any requested records to the department. Review procedures may include but are not limited to the following:

a. Comparing service and fiscal records with each claim.

b. Interviewing clients and employees of providers.

152.3(4) *Sampling.* The department's procedures for reviewing a provider's service records may include the use of random sampling and extrapolation. When these procedures are used, all sampling will be performed within acceptable statistical methods, yielding not less than a 95 percent confidence level.

a. Findings. The review findings generated through the review procedure constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

b. Extrapolation. Findings of the sample will be extrapolated for the review period. The total of the payments determined to be in error in the review sample will be divided by the total payments in the

reviewed sample to calculate the percentage of dollars paid in error. This percentage will then be multiplied by the total payments in the review sample to determine the extrapolated overpayment.

c. Disagreement with findings. When the provider disagrees with the department's review findings and the findings have been generated through sampling and extrapolation, the provider may present evidence to show that the sample was invalid. The burden of proof of compliance rests with the provider. The evidence may include a 100 percent review of the provider records used by the department in the drawing of the department's sample. This review shall:

(1) Be arranged and paid for by the provider.

(2) Be conducted by a certified public accountant.

(3) Demonstrate that bills and records not reviewed in the department's sample complied with program regulations and requirements.

(4) Be submitted to the department with all supporting documentation.

152.3(5) *Actions based on review findings.*

a. The department will report the results of a review of provider records to concerned parties consistent with the provisions of 441—Chapter 2505.

b. When an overpayment is found, the department may do one or more of the following:

(1) Request repayment in writing.

(2) Impose sanctions provided for in rule 441—152.4(234).

(3) Investigate and refer the matter to an agency empowered to prosecute.

[**ARC 0670D**, IAB 10/14/26, effective 12/1/26]

441—152.4(234) Sanctions against providers. Failure to meet the requirements relevant to provider contracting, financial recordkeeping, billing and payment, and client recordkeeping may subject providers to sanctions.

152.4(1) *Grounds for sanction.* The department may impose sanctions against a provider for committing one or more of the following actions:

a. Failing to provide and maintain the quality of the services to children and families within established standards, including:

(1) Failing to meet standards required by state or federal law for licensure.

(2) Failing to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

(3) Engaging in a course of conduct or performing an act that is in violation of state or federal regulations or continuing that conduct following notification that it should cease.

(4) Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions subject to this chapter.

(5) Receiving a formal reprimand or censure by an association of the provider's peers for unethical practices.

(6) Being suspended or terminated from participation in another governmental program.

(7) Committing a negligent practice resulting in client death or injury.

b. Failing to disclose or make available to the department or its authorized agent records of services provided to a child and family and records of payments made for those services.

c. Failing to provide accurate and auditable cost report information or engaging in deceptive billing practices, such as:

(1) Presenting or causing to be presented for payment any false or deceptive claim for services.

(2) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

d. Submitting or causing to be submitted false information to meet service authorization requirements.

e. Inducing, furnishing or otherwise causing the child or family to receive foster care services that are not authorized (overutilization of services).

f. Rebating or accepting a fee or portion of a fee or a charge for referrals of a child or family.

g. Failing to repay or arrange for the repayment of identified overpayments or other erroneous payments.

h. Failing to submit the cost report on time or failing to submit complete responses to follow-up questions from the department or its fiscal consultant within 14 days of request without written approval from the department.

152.4(2) *Notice of violation.*

a. Should the department have information that indicates a provider may have done the following, the department will notify the provider of the discrepancies noted.

(1) Submitted bills or been practicing in a manner inconsistent with the program requirements, or

(2) Received payment for which the provider may not be properly entitled.

b. Notification to the provider will set forth:

(1) The nature of the discrepancies or violations.

(2) The known dollar value of the discrepancies or violations.

(3) The method of computing the dollar value.

(4) Further actions to be taken or sanctions to be imposed by the department.

(5) Any actions required of the provider.

152.4(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in subrule 152.4(1):

a. A term of probation for provision of foster care services.

b. Termination from participation in the provision of foster care services.

c. Suspension from provision of foster care services.

d. Suspension or withholding of payments to the provider.

e. Review of 100 percent of the provider's claims before payment.

f. Referral to the appropriate state licensing board for investigation.

g. Referral of the matter to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

h. Suspension of foster care services licensure.

i. Termination of foster care services licensure.

j. Reduction of payment to 75 percent of the current rate for failure to submit the cost report or cost report clarifications timely.

k. Termination of the provider's contract for failure to submit the report within six months of the end of the fiscal year.

152.4(4) *Imposition and extent of sanction.* The department will determine the sanction to impose. The following factors will be considered in determining the sanction or sanctions to be imposed:

a. Seriousness of the offense.

b. Extent of violations.

c. History of prior violations.

d. Prior imposition of sanctions.

e. Prior provision of technical assistance.

f. Pattern of failure to follow program rules.

g. Whether a lesser sanction will be sufficient to remedy the problem.

h. Actions taken or recommended by peer review groups or licensing bodies.

152.4(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider. Each decision to include an affiliate will be made on a case-by-case basis after giving due regard to all relevant factors and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated when the conduct was committed in the course of official duty or was effectuated with the knowledge or approval of that person.

b. When there are grounds for sanction pursuant to subrule 152.4(1) against a provider facility, campus, or site, the department may suspend or terminate the provision of foster care services by:

(1) The provider; or

(2) The specific facility, campus, or site; or

(3) Any individual within the provider's organization who is responsible for the violation.

c. No provider shall submit claims for payments to the department for any services provided by any facility, campus, site, or person within the organization that has been suspended or terminated from provision of foster care services, except for those services provided before the suspension or termination.

d. Suspension or termination from provision of foster care services shall preclude the submission of claims to the department for payment for any services provided after suspension or termination, whether submitted personally or through the provider.

152.4(6) *Suspension or withholding of payments pending a final determination.* When the department has notified a provider of a violation and has demanded repayment of an identified overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payments pending a final determination. When the department intends to withhold or suspend payments, it will notify the provider in writing.

152.4(7) *Notice of sanction.* When a provider has been sanctioned, the department will notify, as appropriate, the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

[**ARC 0670D**, IAB 10/14/26, effective 12/1/26]

441—152.5(234) Adverse actions. Notice of adverse actions shall be given in accordance with 441—Chapter 16. The right to appeal the licensing decision shall be given in accordance with 441—Chapter 2506.

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These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 153
FUNDING FOR LOCAL SERVICES

[Prior to 7/1/83, see Social Services[770] Ch 131]
[Previously appeared as Ch 131—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/32

441—153.1(234) Development of pre-expenditure report and intended use plan.

153.1(1) The department will develop the social services block grant pre-expenditure report and intended use plan on an annual basis. The report and plan will be developed in accordance with 45 CFR Part 96, Subpart G, as amended to August 1, 2026. The report and plan will describe the services to be funded, the areas in which services are available, and the amount of funding available. The plan will also indicate the source of the funding.

153.1(2) The department will issue a proposed pre-expenditure report and intended use plan before publication of the final report and plan. The proposed report and plan will be available for public review and comment.

153.1(3) The department will announce the time and scope of public review each year. The announcement will indicate where the proposed report and plan can be viewed.

153.1(4) The department will accept comments about the pre-expenditure report and intended use plan during the specified public review and comment period.

153.1(5) The department will consider public comments when developing the final pre-expenditure report and intended use plan.

153.1(6) A copy of the final pre-expenditure report and intended use plan will be available on the department's website.

[**ARC 0771D**, IAB 11/25/26, effective 1/1/27]

441—153.2(234) Amendment to pre-expenditure report and intended use plan.

153.2(1) The pre-expenditure report and intended use plan may be amended throughout the year. The department may file an amendment changing the type, scope or duration of a service. Decisions to change a direct service or state-purchased service will be made by the department. Prior to filing an amendment, the department will evaluate available funds and the effect any change will have on clients.

153.2(2) An amendment in the pre-expenditure report and intended use plan will be posted on the department's website at least 30 days prior to the effective date of the change. However, in the event funding for the service has been exhausted, an amendment will be posted immediately notifying the public that the service will no longer be available.

a. The department will, whenever possible, give advance notice of a service termination made necessary because funds have been exhausted.

b. When a service is added or extended, an amendment may be posted immediately, and a 30-day posting period is not required.

153.2(3) Individuals or groups may submit written comments to the department.

153.2(4) Nothing in this rule will supersede the requirement for notifying clients of adverse action as provided in rule 441—130.5(234).

[**ARC 0771D**, IAB 11/25/26, effective 1/1/27]

441—153.3(234) Service availability.

153.3(1) A client seeking services shall apply for services from the department.

a. The department will determine eligibility according to rule 441—130.3(234).

b. The department will develop a case plan to monitor the client's progress toward achieving goals as identified in rule 441—130.7(234).

153.3(2) A client shall receive a service for which the client is eligible, subject to the provisions of 441—Chapter 130, when the service is listed in the geographic area in which the client resides.

153.3(3) When federal law prohibits the use of federal funds for the social services block grant, state funds shall be used to pay for services to persons the department has defined as eligible.
[**ARC 0771D**, IAB 11/25/26, effective 1/1/27]

441—153.4(234) Allocation of block grant funds.

153.4(1) The department will follow a cost allocation plan for determining the appropriate administrative costs to be funded with block grant moneys.

153.4(2) Funding for services will be allocated in accordance with the annual budgeting process. The department's annual budget is available for review on the department's website. Costs may be shifted in and between service areas to ensure continued statewide availability of services.
[**ARC 0771D**, IAB 11/25/26, effective 1/1/27]

441—153.5(234) Expenditure of supplemental funds. When supplemental funds are issued through the social services block grant as emergency disaster relief, the department will administer the funds in compliance with the terms of the federal award.
[**ARC 0771D**, IAB 11/25/26, effective 1/1/27]

These rules are intended to implement Iowa Code section 234.6 and 2026 Iowa Acts, Senate File 2488, division II.

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CHAPTER 154

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

[See 441—Chapter 168]

CHAPTER 155
CHILD ABUSE PREVENTION PROGRAM

[Prior to 7/1/83, Social Services[770] Ch 146]
[Previously appeared as Ch 146—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

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PREAMBLE

These rules define and structure the child abuse prevention program. Services are provided through multiple local grant projects, as well as a single statewide performance-based contract for the administration of community-based child abuse prevention projects.

[**ARC 3495C**, IAB 12/6/17, effective 1/10/18]

441—155.1(235A) Definitions.

"Advisory committee" or *"committee"* means the child abuse prevention program advisory committee authorized by Iowa Code section 217.3A.

"Child abuse prevention program" or *"program"* means the program established by Iowa Code section 235A.1. Use of either term in the context of this chapter refers to the program as a whole rather than individual projects funded under the program.

"Community-based volunteer coalition or council" or *"community council"* means that group of persons who, by consensus of a community's human service providers, represent that community's interests in the area of prevention of child abuse and neglect and who serve in that representational capacity without compensation. The consensus of the community's human service providers may be demonstrated through letters of support or similar documentation.

"Contractor" means the single agency or organization with which the department contracts for the administration of the child abuse prevention program.

"Department" means the Iowa department of human services.

"Director" means the director of the department of human services.

"Fiscal year" means the 12-month period for which child abuse prevention program funds are appropriated.

"Grant project" means a project funded under the child abuse prevention program as awarded by the department.

[**ARC 9489B**, IAB 5/4/11, effective 4/15/11; **ARC 3495C**, IAB 12/6/17, effective 1/10/18]

441—155.2(235A) Contract for program administration. The department shall contract for the administration of the child abuse prevention program through formal competitive procurement conducted according to all applicable state and federal procurement laws.

155.2(1) *Eligibility requirements.* Eligibility for the program administration contract is limited to statewide agencies or organizations that make maximum use of voluntary administrative services.

155.2(2) *Duties.* The department shall contract with a single agency or organization to:

a. Administer the grant projects awarded through the appropriated funds and any grants, gifts or bequests to the department that are specifically designated by their source for use in the child abuse prevention program; and

b. Study and evaluate community-based prevention projects and educational programs for the problems of families and children in accordance with the provisions of Iowa Code section 235A.1 and this chapter.

[**ARC 9489B**, IAB 5/4/11, effective 4/15/11; **ARC 3495C**, IAB 12/6/17, effective 1/10/18]

441—155.3(235A) Awarding of grants. In any year in which funding is appropriated or otherwise made available for the child abuse prevention program, the contractor shall solicit new grant project proposals or renew existing projects when eligible and in accordance with all applicable state and federal procurement laws. Funds for the grant projects shall be applied for and received by community-based

volunteer coalitions or councils. Grant projects may be awarded to fund the establishment or expansion of community-based prevention projects or educational programs for the prevention of child abuse and neglect.

155.3(1) The advisory committee shall establish specific program goals for each fiscal year in which program funds are appropriated and new contracts are issued. These program goals shall address the current and emerging needs of children and families throughout the state.

155.3(2) The contractor shall assist the department in widely disseminating a request for grant project proposals consistent with all state and federal procurement requirements. The request for grant project proposals shall fully describe the child abuse prevention program goals and the procedures for applying for and receiving program funds.

155.3(3) All grant project proposals shall be reviewed by an independent review committee in accordance with all applicable state and federal procurement laws. The contractor shall assist the department in the review and shall consult with the advisory committee on grant project award recommendations. The department will consider the recommendations of the committee but will have final decision-making authority on the awarding of grantee contracts. The committee shall advise the department as to the contractor's compliance with the established program goals.

[**ARC 9489B**, IAB 5/4/11, effective 4/15/11; **ARC 3495C**, IAB 12/6/17, effective 1/10/18]

441—155.4(235A) Grantee requirements. In order to receive funding from the department, community councils must be legal entities or must designate a legal entity to receive the project funds directly (e.g., a local service provider).

155.4(1) Grantees, or the identified service providers, shall participate in program evaluation as required by the contractor and the department.

155.4(2) The department shall cause participant data to be entered into the state-administered, Internet-based data collection system identified in Iowa Code section 256I.13(3) and maintained by the Iowa department of public health. This release of information by the department is required by law, and as such, data entered into the system maintained by the Iowa department of public health will no longer be protected by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and associated implementing regulations found at 45 CFR Parts 160, 162, and 164 as amended to August 3, 2022. In addition, no information gathered by grantees and disclosed pursuant to this subrule is gathered for purposes of treating individuals for substance abuse. As such, the data disclosed pursuant to this subrule is not protected by 42 U.S.C. §290dd-2 as amended to August 3, 2022, or by the implementing regulations found at 42 CFR 2 as amended to August 3, 2022. In addition, the substance abuse treatment information so released is not subject to the confidentiality provisions of Iowa law found at Iowa Code sections 125.37 and 125.93.

[**ARC 3495C**, IAB 12/6/17, effective 1/10/18; **ARC 5363C**, IAB 12/30/20, effective 3/1/21; Editorial change: IAC Supplement 8/24/22]

These rules are intended to implement Iowa Code sections 235A.1 and 235A.2.

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CHAPTER 156
PAYMENTS FOR FOSTER CARE

[Prior to 7/1/83, Social Services[770] Ch 137]
[Previously appeared as Ch 137—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/31

441—156.1(234) Definitions.

"Child welfare services" means age-appropriate activities to maintain a child's connection to the child's family and community, to promote reunification or other permanent placement, and to facilitate a child's transition to adulthood.

"Cost of foster care" means the maintenance and supervision costs of foster family care, the maintenance costs and child welfare service costs of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and for supervised apartment living services provided directly by the department caseworker is $250 per month. When using this average monthly charge results in unearned income or parental liability being collected in excess of the cost of foster care, the excess funds will be placed in the child's escrow account. The cost for supervised apartment living services purchased from a private provider are to be the actual costs paid by the department.

"Earned income" means income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from job corps or profit from self-employment.

"Escrow account" means an interest-bearing account in a bank or savings and loan association that is maintained by the department in the name of a particular child.

"Family foster care supervision" means the support, assistance, and oversight provided by department caseworkers to children in family foster care and directed toward achievement of the child's permanency plan goals.

"Foster care" means substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care includes but is not limited to the provision of food, lodging, training, education, supervision and health care.

"Foster family care" means foster care provided by a foster family licensed by the department according to 441—Chapter 113, approved by the department according to Iowa Code chapter 237, or licensed or approved by the placing state. The care includes the provision of food, lodging, clothing, transportation, recreation, and training that is appropriate for the child's age and mental and physical capacity.

"Group care maintenance" means food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, and supervision of children to ensure their well-being and safety, and administration of maintenance items provided in a group care facility.

"Income" means earned and unearned income.

"Inflation factor" means the amount by which the consumer price index for all urban consumers increased during the calendar year ending December 31 that preceded the contractor's fiscal year end.

"Intellectual disabilities professional" means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and has at least one year of experience working with persons with an intellectual disability.

"Kinship caregiver" means, for this chapter only, a person to whom a child is related by blood, marriage, or adoption, or a person who has a significant, committed, positive relationship with the child, who is caring for a child in foster care pursuant to Iowa Code chapter 232.

"Kinship foster care approval" means the authorization granted to the caregiver by the department to provide child foster care through an expedited process according to Iowa Code chapter 237 and allows

the kinship caregiver to receive maximum financial support and to obtain the information and resources necessary to meet the needs of a child under a court-ordered placement with the kinship caregiver.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field, including but not limited to psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Parent" means the biological or adoptive parent of the child.

"Parental liability" means a parent's liability for the support of a child during the period of foster care placement. Liability is determined pursuant to 441—Chapter 99.

"Physician" means a licensed medical or osteopathic doctor as defined in Iowa Code section 135.1(4).

"Prevailing rate" means the maximum combined service and maintenance reimbursement rate the department pays to contracted shelter care providers as authorized by the legislature.

"Provider" means the entity that has executed a contract with the department to provide services.

"Service area manager" means the department employee or designee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Special needs child" means a child with needs for emotional care, behavioral care, or physical and personal care that require additional skills, knowledge, or responsibility on the part of the foster parents, as measured by Form 470-4401, Foster Child Behavioral Assessment.

"Unearned income" means any income that is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.2(234) Foster care recovery. The department will recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, which establishes policies and procedures for the computation and collection of parental liability by child support services.

156.2(1) Funds are to be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

a. Unearned income of the child.

b. Parental liability of the noncustodial parent.

c. Parental liability of custodial parent(s).

156.2(2) The department serves as payee to receive the child's unearned income. When a parent or guardian is not available or is unwilling to do so, the department is responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

156.2(3) The custodial parent shall assign child support payments to the department.

156.2(4) Unearned income of a child and parental liability of the noncustodial parent is placed in an account from whence it is applied toward the cost of the child's current foster care and the remainder placed in an escrow account.

156.2(5) When a child has funds in escrow, these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

156.2(6) When the child leaves foster care, funds in escrow are paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority unless a guardian has been appointed.

156.2(7) When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) is made available to the child and the child's parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.3(234) Rate of maintenance payment for foster family care.

156.3(1) *Basic rate.* A monthly payment for care in a foster family home licensed in Iowa will be made to the foster family based on the following schedule:

Age of child	Daily rate
0 through 5	$18.50
6 through 11	$19.24
12 through 15	$21.06
16 or over	$21.34

156.3(2) *Out-of-state rate.* A monthly payment for care in a foster family home licensed or approved in another state will be made to the foster family based on the rate schedule in effect in Iowa, except that the service area manager or designee may authorize a payment to the foster family at the rate in effect in the other state if the child's family lives in that state and the goal is to reunite the child with the family.

156.3(3) *Mother and child in foster care.* When the child in foster care is a mother whose young child is in placement with her, the rate paid to the foster family is based on the daily rate for the mother according to the rate schedule in subrules 156.6(1) and 156.6(4) and for the child according to the rate schedule in subrule 156.6(1). The foster parents shall provide a portion of the young child's rate to the mother to meet the partial maintenance needs of the young child as defined in the case permanency plan.

156.3(4) *Kinship foster care.* When the child in foster care is court-ordered to placement with an approved kinship caregiver to provide child foster care, the rate paid to the approved kinship caregiver is based on the daily amount according to the rate schedule in subrule 156.6(1).

a. When a foster family provides care to a sibling group of three or more children, an additional payment of $1 per day per child may be authorized for each nonspecial needs child in the sibling group.

b. When the foster family's responsibilities in the case permanency plan include providing transportation related to family or preplacement visits outside the community in which the foster family lives, the department caseworker may authorize an additional maintenance payment of $1 per day. Expenses over the monthly amount may be reimbursed with prior approval by the department caseworker. Eligible expenses include the actual cost of the most reasonable passenger fare or gas.

c. A supervisor may approve an additional maintenance payment above the basic rate in subrule 156.6(1) to meet the child's special needs as identified by the child's score on Form 470-4401, Foster Child Behavioral Assessment. The department caseworker will complete Form 470-4401, Foster Child Behavioral Assessment, within 30 days of the child's initial entry into foster care.

(1) Additional maintenance payments made under this paragraph can begin no earlier than the first day of the month following the month in which Form 470-4401, Foster Child Behavioral Assessment is completed and will be awarded as follows:

1. Behavioral needs rated at level 1 qualify for a payment of $4.81 per day.
2. Behavioral needs rated at level 2 qualify for a payment of $9.62 per day.
3. Behavioral needs rated at level 3 qualify for a payment of $14.44 per day.

(2) The department will review the child's need for this difficulty of care maintenance payment using Form 470-4401, Foster Child Behavioral Assessment:

1. Whenever the child's behavior changes significantly;
2. When the child's placement changes;

3. After termination of parental rights, in preparation for negotiating an adoption subsidy or pre-subsidy payment; and

4. Before a court hearing on guardianship subsidy.

d. All maintenance payments, including difficulty of care payments, are to be documented on Form 470-0716, Foster Family Placement Contract.

156.3(5) *Payment method.* All foster family maintenance payments shall be made directly to the foster family.

156.3(6) *Return of overpayments.* When a foster family has received payments in excess of those allowed under this chapter, the department caseworker shall ask the foster family to return the overpayment. If the foster family is returning the overpayment to the department, the department caseworker shall note the monthly amount the foster family agrees to pay in the family's case file. The amount returned cannot be less than $50 per month.

This rule is intended to implement Iowa Code section 234.38 and chapter 237.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.4(234) Kinship caregiver payment.

156.4(1) A kinship caregiver payment is a monthly payment to financially support the care of a child in a kinship caregiver's home. If approved by the department, kinship caregiver payment will be provided for a period of up to four months.

156.4(2) All of the following conditions apply:

a. For each eligible child living in a kinship placement, a caregiver will receive a monthly payment according to the basic rate schedule in subrule 156.6(1) as a result of a court-ordered placement.

b. The payment will begin after 14 days of the child's placement in the kinship caregiver's home. The 14-day requirement is waived if the child enters the kinship caregiver's home immediately following a paid placement for at least 30 days.

c. The payment will continue for up to four months.

d. The kinship caregiver payment will be terminated if the child no longer resides in the home.

e. Kinship caregivers who receive a foster care payment are not eligible to receive a kinship caregiver payment.

This rule is intended to implement Iowa Code section 232.102.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.5(234) Additional payments.

156.5(1) *Clothing allowance.*

a. When, in the judgment of the department caseworker, clothing is needed at the time the child is removed from the child's home and placed in foster care and annually thereafter as needed based on the date the child entered foster care, an allowance may be authorized, not to exceed $500 for the child through the age of 12 and $750 for the child aged 13 and older, to purchase clothing.

b. When clothing is purchased by the foster family, the foster family shall submit receipts to the department caseworker within 30 days of purchase for auditing purposes, using Form 470-1952, Foster Care Clothing Allowance.

156.5(2) *Supervised apartment living.* When a child is initially placed in supervised apartment living, the service area manager or designee may authorize an allowance not to exceed $630 if the child does not have sufficient resources to cover initial costs.

156.5(3) *Medical care.* When a child in foster care needs medical care or examinations that are not covered by the Medicaid program and no other source of payment is available, the cost may be paid from foster care funds with the approval of the service area manager or designee. Eligible costs include emergency room care, medical treatment by out-of-state providers who refuse to participate in the Iowa Medicaid program, and excessive expenses for nonprescription drugs or supplies. Requests for payment for out-of-state medical treatment and for nonprescription drugs or supplies shall be approved prior to the care being provided or the drugs or supplies purchased. Claims shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the service is provided. The rate of payment will be the same as allowed under the Iowa Medicaid program.

156.5(4) *Transportation for medical care.* When a child in foster family care has expenses for transportation to receive medical care that cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the service area manager. The claim for all the expenses shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the trip. This payment cannot duplicate or supplement payment through the Medicaid program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

156.5(5) *Funeral expense.* When a child under the guardianship of the department dies, the department will pay funeral expenses not covered by the child's resources, insurance or other death benefits, the child's legal parents, or the child's county of legal settlement, not to exceed $650. The claim shall be submitted by the funeral director to the department on Form GAX, General Accounting Expenditure, and approved by the service area manager. Claims shall be submitted within 90 days after the child's death.

156.5(6) *School fees.* Payment for required school fees of a child in foster family care or supervised apartment living that exceeds $5 may be authorized by the department caseworker in an amount not to exceed $50 per calendar year if the child does not have sufficient escrow funds to cover the cost. Required school fees include:

a. Fees required for participation in school or extracurricular activities; and

b. Fees related to enrolling a child in preschool when a mental health professional or an intellectual disabilities professional has recommended school attendance.

156.5(7) *Respite care.* Respite care for a child in family foster care shall be for up to 24 days per calendar year per placement. Except for a certified respite provider, respite shall be provided by a licensed foster family. The payment rate to the respite foster family is the rate authorized under rule 441—156.6(234) to meet the needs of the child. Certified respite providers deliver foster child respite services in the foster family home for at least five hours a day at $20 per day.

156.5(8) *Tangible goods, child care, and ancillary services.* To the extent that a foster child's escrow funds are not available, the service area manager or designee may authorize reimbursement to foster parents for the following:

a. Tangible goods for a special needs child, including but not limited to building modifications, medical equipment not covered by Medicaid, specialized educational materials not covered by educational funds, and communication devices not covered by Medicaid.

b. Child care services when the foster parents are working, the child is not in school, and the provision of child care is identified in the child's case permanency plan.

(1) Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

(2) When foster parents elect to become child care providers, they shall be registered pursuant to 441—Chapter 110.

c. Ancillary services needed by the foster parent to meet the needs of a special needs child, including but not limited to specialized classes when directed by the case permanency plan.

d. Ancillary services needed by the special needs child, including but not limited to recreation fees, in-home tutoring and specialized classes not covered by education funds.

e. Requests for tangible goods, child care, and ancillary services shall be submitted to the service area manager for approval on Form 470-3056, Request for Tangible Goods, Child Care, and Ancillary Services. Payment rates for tangible goods and ancillary services will be comparable to prevailing community standards. Payment rates for child care are established pursuant to 441—subrule 170.4(7).

f. Prior payment authorization will be issued by the service area manager before tangible goods, child care, and ancillary services are purchased by or for foster parents.

This rule is intended to implement Iowa Code section 234.38.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.6(234) Rate of payment for foster group care.

156.6(1) *In-state reimbursement.* Contracted foster group care facilities licensed or approved in the state of Iowa will be paid for group care maintenance and child welfare services in accordance with contracted terms.

a. Additional payment for group care maintenance may be authorized if a facility provides care for a mother and her young child according to subrule 156.9(4).

b. No less than annually, the department will redetermine the allocation of the combined child welfare service per diem rate between the maintenance and service portions plus the inflation factor based on review of the verified Form 470-5421, Combined Cost Report. If the new allocation differs from the current allocation, the department will:

(1) Reallocate the combined child welfare service per diem for foster group care between the maintenance and service portions plus the inflation factor of the combined rate; and

(2) Notify all providers of any change in the allocation between maintenance and service rates.

156.6(2) *Out-of-state group care payment rate.* When the department determines that appropriate care is not available in Iowa and a licensed or approved contractor outside Iowa is used, the payment rate for contracted foster group care services will be the Iowa rate unless the director grants an exception. The rate cannot exceed the rate paid for clients from that state.

156.6(3) *Out-of-state placement determination.*

a. Placement. When determining whether appropriate care is available within the state, the director will consider each of the following:

(1) Whether the child's treatment needs are exceptional.

(2) Whether appropriate in-state alternatives are available.

(3) Whether an appropriate in-state alternative could be developed by using juvenile court-ordered service funds or wrap-around funds.

(4) Whether the placement and additional payment are expected to be time-limited with anticipated outcomes identified.

(5) If the placement has been approved by the service area manager or chief juvenile court officer.

b. Procedure. The service area manager or chief juvenile court officer will submit the request for director's exception to the department. This request will be made in advance of placing the child and should allow a minimum of two weeks for a response. The request should contain documentation addressing the criteria for director's approval listed in paragraph 156.6(3)*"a."*

156.6(4) *Mother-young child rate.* When a group foster care facility provides foster care for a mother and her young child, an additional maintenance rate will cover the maintenance needs of the young child. No additional amount is allowed for service needs of the child.

a. The rate is set in the provider contract. The young child maintenance rate is limited to the costs associated with food, clothing, shelter, personal incidentals, and supervision for each young child and cannot exceed the maintenance rate for the mother. Costs for day care cannot be included in the maintenance rate.

b. Unless the court has transferred custody from the mother, the mother shall have primary responsibility for providing supervision and parenting for the young child. The facility shall provide services to the mother to assist her to meet her parenting responsibilities and monitor her care of the young child.

c. The provider shall provide services to the mother to assist her to:

(1) Obtain a high school diploma or high school equivalency.

(2) Develop preemployment skills.

(3) Establish paternity for her young child whenever appropriate.

(4) Obtain child support for the young child whenever paternity is established.

d. The provider shall maintain information in the mother's file on:

(1) The involvement of the mother's parents or of other adults.

(2) The involvement of the father of the minor's child, including steps taken to establish paternity, if appropriate.

(3) A decision of the minor to keep and raise her young child.

(4) Plan for the minor's completion of high school or a high school equivalency program.

(5) The parenting skills of the minor parent.

(6) Child care and transportation plans for education, training or employment.

(7) Ongoing health care of the mother and child.

(8) Other services as needed to address personal or family problems or to facilitate the personal growth and development toward economic self-sufficiency of the minor parent and young child.

e. The provider designates $35 of the young child rate as an allowance to the mother to meet the maintenance needs of her young child, as defined in her case permanency plan.

This rule is intended to implement Iowa Code sections 234.6 and 234.38.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.7(234) Payment for reserve bed days.

156.7(1) *Group care facilities.* The department will provide payment for group care maintenance and child welfare services according to the following requirements.

a. Family visits. Reserve bed payment will be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The facility shall notify the department caseworker of each visit and its planned length prior to the visit.

(3) The intent of the department and the facility will be for the child to return to the facility after the visit.

(4) Staff from the facility shall be available to provide support to the child and family during the visit.

(5) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(6) If the department and the facility agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(7) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case can payment exceed 30 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Hospitalization. Reserve bed payment will be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the department caseworker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(6) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case can payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. Runaways. Reserve bed payment will be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the department caseworker within 24 hours after the child runs away.

(2) The intent of the department and the facility will be for the child to return to the facility once the child is found.

(3) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(4) If the department and the facility agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(5) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 30 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. Preplacement visits. Reserve bed payment will be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility will be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment will be canceled and payment shall be returned if the facility refuses to accept the child back.

(5) Payment will not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

156.7(2) *Foster family care.*

a. Family visits. Reserve bed payment will be made for days a foster child is absent from the foster family home for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family will be for the child to return to the foster family home after the visit.

(3) Payment will be canceled and payments shall be returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(5) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 30 consecutive days.

b. Hospitalization. Reserve bed payment will be made for days a foster child is absent from the foster family home for hospitalization when the absence is in accord with the following:

(1) The intent of the department and the foster family will be for the child to return to the foster family home after the hospitalization.

(2) Payment will be canceled and payments shall be returned if the foster family refuses to accept the child back.

(3) If the department and the foster family agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(4) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(5) Payment will not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

c. Runaways. Reserve bed payment will be made for days a foster child is absent from the foster family home after the child has run away when the absence is in accord with the following:

(1) The foster family shall notify the department caseworker within 24 hours after the child runs away.

(2) The intent of the department and the foster family will be for the child to return to the foster family home once the child is found.

(3) Payment will be canceled and payments shall be returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(5) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment cannot exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 30 consecutive days.

d. Preplacement visits. Reserve bed payment will be made when a foster child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family home will be for the child to return to the foster family home.

(3) Payment will be canceled and payment shall be returned if the foster family home refuses to accept the child back.

(4) Payment cannot exceed two consecutive days.

156.7(3) *Shelter care facilities.*

a. Hospitalization. Reserve bed payment will be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the department caseworker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility will be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(6) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment cannot exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Preplacement visits. Reserve bed payment will be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility will be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment will be canceled and payment shall be returned if the facility refuses to accept the child back.

(5) Payment will not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. Family visits. Reserve bed payment will be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The facility shall notify the department caseworker of each visit and its planned length prior to the visit.

(3) The intent of the department and the facility will be for the child to return to the facility after the visit.

(4) Staff from the facility shall be available to provide support to the child and family during the visit.

(5) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(6) If the department agrees that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(7) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment cannot exceed seven consecutive days, except upon prior written approval of the service area manager. In no case will payment exceed 14 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. Runaways. Reserve bed payment will be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the department caseworker within 24 hours after the child runs away.

(2) The intent of the department and the facility will be for the child to return to the facility once the child is found.

(3) Payment will be canceled and payments shall be returned if the facility refuses to accept the child back.

(4) If the department agrees that the return would not be in the child's best interest, payment will be canceled effective the day after the joint decision not to return the child.

(5) Payment will be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment cannot exceed seven consecutive days, except upon prior written approval of the service area manager. In no case can payment exceed 14 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

This rule is intended to implement Iowa Code sections 234.6 and 234.35.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.8(234) Emergency juvenile shelter care payment. Contracted juvenile shelter care facilities approved or licensed in Iowa will be paid in accordance with contracted terms, not to exceed the allowable costs as permitted by Iowa Code section 232.141(8).

This rule is intended to implement Iowa Code sections 234.6 and 234.39.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.9(234) Supervised apartment living.

156.9(1) *Child monthly stipend.* For each eligible child living in a supervised apartment living situation, the monthly stipend payment for the child is $787.50. This payment may be paid to the child or another payee, other than a department employee, for the child's living expenses.

156.9(2) *Service.* When services for a youth in supervised apartment living are purchased, the service components and any special provisions shall be specified by the service worker in the youth's case permanency plan.

This rule is intended to implement Iowa Code section 234.35.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.10(234,252C) Voluntary placements. When placement is made on a voluntary basis, the parent or guardian shall complete and sign Form 470-0715, Voluntary Placement Agreement.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.11(234) Child's earnings. Earned income of a child who is in foster care shall be reported to the department, and the earned income's use shall be part of the child's plan for service, but the income cannot be used towards the cost of the child's care as established by the department.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.12(234) Trust funds and investments.

156.12(1) When the child is a beneficiary of a trust and the proceeds therefrom are not currently available, or are not sufficient to meet the child's needs, the worker will assist the child in having a petition presented to the court requesting release of funds to help meet current requirements. When the child and responsible adult cooperate in necessary action to obtain a ruling of the court, income cannot be considered available until the decision of the court has been rendered and implemented. When the child and responsible adult do not cooperate in the action necessary to obtain a ruling of the court, the trust fund or investments will be considered as available to meet the child's needs immediately. When the child or responsible adult does not cooperate within 90 days in making the income available, the maintenance payment is terminated.

156.12(2) The department is the payee for income from any trust funds or investments unless limited by the trust.

156.12(3) Savings accounts from any income and proceeds from the liquidation of securities shall be placed in the child's account maintained by the department and any amount in excess of $1,500 is applied towards cost of the child's maintenance.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.13(234) Preadoptive homes. Payment for a foster child placed in a preadoptive home is limited to the amount negotiated pursuant to rule 441—201.5(600) and cannot exceed the foster care maintenance amount paid in family foster care.

This rule is intended to implement Iowa Code section 234.38.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

441—156.14(234) Eligibility for foster care payment.

156.14(1) *Client eligibility.* Foster care payment is limited to the following populations.

a. Youth under the age of 18 are eligible based on legal status, subject to certain limitations.

(1) Legal status. The youth's placement will be based on one of the following legal statuses:

1. The court has ordered foster care placement pursuant to Iowa Code section 232.52(2)*"d,"* 232.102(1), or 232.117.

2. The child is placed in shelter care pursuant to Iowa Code section 232.20(1) or 232.21.

3. The department has agreed to provide foster care under a voluntary placement agreement pursuant to rule 441—202.3(234).

(2) Limitations. Department payment for group care is limited to placements that have been authorized by the department and that conform to the service area group care plan developed pursuant to rule 441—202.17(232). Payment for an out-of-state group care placement shall be limited to placements approved pursuant to 441—subrule 202.8(2).

b. Youth aged 18 and older who meet the definition of child in rule 441—202.1(234) are eligible based on age, a voluntary placement agreement pursuant to 441—subrule 202.3(3), and type of placement.

(1) Except as provided in subparagraph 156.14(1)*"b"*(3), payment for a child who is 18 years of age is limited to family foster care or supervised apartment living.

(2) Except as provided in subparagraph 156.14(1)*"b"*(3), payment for a child who is 19 years of age will be limited to supervised apartment living.

(3) Exceptions. An exception to subparagraphs 156.14(1)*"b"*(1) and *"b"*(2) will be granted for all unaccompanied refugee minors. The child's eligibility for the exception will be documented in the case record. The service area manager or designee will grant an exception for other children when the child meets all of the following criteria.

1. The child does not have an intellectual disability.

2. The child is at imminent risk of becoming homeless or of failing to graduate from high school or obtain a general equivalency diploma. "At imminent risk of becoming homeless" means that a less restrictive living arrangement is not available.

3. The placement is in the child's best interests.

4. Funds are available in the service area's allocation. When the service area manager has approved payment for foster care pursuant to this subparagraph, funds that may be necessary to provide payment for the time period of the exception, not to exceed the current fiscal year, will be considered encumbered and no longer available. Each service area's funding allocation will be based on the service area's portion of the total number of children in foster care on March 31 preceding the beginning of the fiscal year, who would no longer be eligible for foster care during the fiscal year due to age, excluding unaccompanied refugee minors.

c. A young mother is eligible for the extra payment for her young child living with her in care as set forth in subrules 156.3(3) and 156.6(4) and if all of the following apply:

(1) The mother is placed in foster care.

(2) The mother's custodian determines, as documented in the mother's case permanency plan, that it is in her best interest and the best interest of the young child that the child remain with her.

(3) A placement is available.

(4) The mother agrees to refund to the department any child support payments she receives on behalf of the child and to allow the department to be made payee for any other unearned income for the child.

156.14(2) *Provider eligibility for payment.* Providers of foster care services shall have a foster care services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 234.35 and 234.38.

[**ARC 0074D**, IAB 2/18/26, effective 4/1/26]

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◊ Two or more ARCs

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CHAPTER 157
PURCHASE OF ADOPTION SERVICES
[Prior to 2/11/87, Human Services [498]]
Rescinded IAB 5/6/09, effective 7/1/09

CHAPTER 158
FOSTER HOME INSURANCE FUND

Chapter rescission date pursuant to Iowa Code section 17A.7: 12/1/31

441—158.1(237) Definitions.

"Foster family home" means the same as defined in Iowa Code section 237.1.

"Personal property" means any movable thing of value that is owned, rented, or leased by a person and not recognized as real property.

"Real property" means anything owned, leased, or rented that is permanently affixed to, or built upon, a piece of land. Real property is best characterized as property that does not move or that is attached to the land.

"Third-party property" means property belonging to any person or entity other than the foster family or foster child.

[**ARC 0671D**, IAB 10/14/26, effective 12/1/26]

441—158.2(237) Payments from the foster home insurance fund.

158.2(1) Eligible foster family claims. The foster home insurance fund shall pay the following within the limits defined in Iowa Code section 237.13(1):

a. Valid and approved claims of a licensed foster family home.

b. Compensation to licensed foster families for personal or real property damage and auto physical damage as a result of the activities of the family foster care child. Coverage also extends to third-party property damages caused by actions of the family foster care child.

158.2(2) Non-property-based liability, bodily injury, sexual abuse or molestation, auto liability, and professional liability are not covered.

[**ARC 0671D**, IAB 10/14/26, effective 12/1/26]

441—158.3(237) Payment limits. The fund is not liable for the first $150 per claim deductible per family. Each claim is limited to one incident/occurrence. The fund is not liable for damages in excess of $5,000 for all claims arising out of one or more occurrences during a fiscal year related to a single home. Claims for losses related to bedbugs or other insect infestations will have an annual sublimit set by the department.

[**ARC 0671D**, IAB 10/14/26, effective 12/1/26]

441—158.4(237) Claim procedures. Claims against the fund are filed with the department's approved contractor. Claims shall be filed on the Foster Home Property Fund Notice of Loss form. The decision to approve or deny the claim will be made by the department. The claimant will be notified of the decision within 180 days of the date the claim is received.

158.4(1) *Time frame for filing claims.* Claims shall be submitted within six months of the date of the occurrence.

158.4(2) *Appeals.* Claimants dissatisfied with the decision may request a fair hearing under the provisions of 441—Chapter 2506.

[**ARC 0671D**, IAB 10/14/26, effective 12/1/26]

These rules are intended to implement Iowa Code section 237.13.

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CHAPTER 159
CHILD CARE RESOURCE AND REFERRAL SERVICES
Rescinded **ARC 0141D**, IAB 3/18/26, effective 4/22/26

CHAPTER 160
ADOPTION OPPORTUNITY GRANT PROGRAM
Rescinded **ARC 6504C**, IAB 9/7/22, effective 11/1/22

CHAPTER 161
IOWA SENIOR LIVING TRUST FUND
Rescinded **ARC 6392C**, IAB 6/29/22, effective 9/1/22

CHAPTER 162
NURSING FACILITY CONVERSION
AND LONG-TERM CARE SERVICES
DEVELOPMENT GRANTS
Rescinded **ARC 6392C**, IAB 6/29/22, effective 9/1/22

CHAPTER 163
ADOLESCENT PREGNANCY PREVENTION AND SERVICES
TO PREGNANT AND PARENTING ADOLESCENTS
PROGRAMS
Rescinded **ARC 0261D**, IAB 5/13/26, effective 7/1/26

CHAPTER 164
MORE OPTIONS FOR MATERNAL SUPPORT (MOMS) PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

441—164.1(217) Definitions.

"Client" means an individual receiving the services enumerated in Iowa Code section 217.41C through the program.

"Pregnancy support services" means the same as defined in Iowa Code section 217.41C.

"Program" means the more options for maternal support (MOMS) program outlined in Iowa Code section 217.41C.

"Program administrator" means the department or a nonprofit entity incorporated in this state with a tax-exempt status pursuant to Section 501(c)(3) of the Internal Revenue Code that is awarded a contract by the department to administer the program, including managing a statewide network of providers and other duties outlined in Iowa Code section 217.41C.

"Provider of pregnancy support services" or *"provider"* means the same as defined in Iowa Code section 217.41C.

[**ARC 9105C**, IAB 4/16/25, effective 6/1/25]

441—164.2(217) Pregnancy support services. Pregnancy support services do not include health care treatment or services for purposes of the Health Insurance Portability and Accountability Act of 1996.

[**ARC 9105C**, IAB 4/16/25, effective 6/1/25]

441—164.3(217) Program administrator responsibilities.

164.3(1) If a nonprofit entity is awarded a contract by the department though the request for proposals process to administer the program, that program administrator may assume ownership and oversight of any existing contracts providers have with the department. The program administrator will work with the department to facilitate and execute the contract reassignments.

164.3(2) A program administrator shall prepare and submit an annual program evaluation report in a format prescribed by the department at the end of each contracted year. The program administrator shall use the results of the evaluation report at a minimum to support and assist providers in the continuous quality improvement process.

164.3(3) A program administrator shall maintain a minimum number of providers, as specified by the department, to include any provider contracts reassigned by the department, if applicable.

164.3(4) A program administrator shall only be eligible to receive reimbursement for services described in its contract and shall not charge additional fees to the department or to providers.

[**ARC 9105C**, IAB 4/16/25, effective 6/1/25]

441—164.4(217) Client feedback. The department will create a process for clients to provide confidential feedback regarding their experience with providers.

[**ARC 9105C**, IAB 4/16/25, effective 6/1/25]

441—164.5(217) Appeals. An applicant for program administrator, provider, or client who disagrees with a decision of the department may submit an appeal in accordance with 441—Chapter 2506.

[**ARC 9105C**, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 217.41C.

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CHAPTER 165
FAMILY DEVELOPMENT AND SELF-SUFFICIENCY PROGRAM
Rescinded IAB 9/8/10, effective 9/1/10

CHAPTER 166
QUALITY IMPROVEMENT INITIATIVE GRANTS

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/31

441—166.1(249A) Definitions.

"Eligible entities" means certified long-term care facilities, professional or state nursing home associations, state agencies, consumer and nursing facility advocacy organizations, resident and family councils, and private applicants.

"Nursing facility" means a Medicaid-enrolled facility that is defined in rule 441—81.1(249A) as "facility."

"Quality improvement initiative" or *"initiative"* means a project or training in accordance with provisions of 42 CFR 488.433 as amended to August 1, 2026, that directly or indirectly supports and benefits the quality of care and quality of life of nursing facility residents.

[**ARC 0459D**, IAB 8/5/26, effective 10/1/26]

441—166.2(249A) Availability of grants. The department will set aside an annual amount from the civil money penalty fund established pursuant to Iowa Code section 249A.57 to be awarded in the form of emergency reserve fund grants to eligible entities for approved support and protection of residents of a facility that closes (voluntarily or involuntarily). At no time shall the grant set-aside cause the civil money penalty emergency reserve fund to drop below $1 million.

166.2(1) In any calendar year in which sufficient funds are available in the civil money penalty fund to support quality improvement initiative grants, the department may issue a notice for applications for grants.

166.2(2) There is no entitlement to any funds available for grants awarded pursuant to this chapter. The department may award grants to the extent funds are available and, within its discretion, to the extent that applications are approved.

166.2(3) The project plan as described in rule 441—166.4(249A) and allocation of funds shall be in compliance with state and federal laws and approved by the Centers for Medicare and Medicaid Services (CMS).

166.2(4) Emergency reserve fund grants are available for purposes of:

a. Time-limited expenses incurred in the process of relocating residents when a facility closes (voluntarily or involuntarily) or downsizes pursuant to an agreement with the department, and

b. Development and maintenance of temporary management or receivership capability.

[**ARC 0459D**, IAB 8/5/26, effective 10/1/26]

441—166.3(249A) Grant eligibility. Grants are available for quality improvement initiatives that are outside the scope of normal operations for the nursing facility or other applicants. Grants cannot be used as replacement funding for goods or services that the applicant already offers.

166.3(1) Grants may be awarded for:

a. Short-term quality improvement initiatives (three years or less), and

b. Situations eligible for emergency reserve funds.

166.3(2) The department will comply with CMS guidance on civil money penalty uses.

[**ARC 0459D**, IAB 8/5/26, effective 10/1/26]

441—166.4(249A) Grant application process and selection of proposals. The department will announce through a request for proposals the opening of an application period. The request will state the purpose for which grant funds may be sought. Applicants shall submit their grant proposals by the deadline specified in the announcement.

166.4(1) All proposals completed as directed and submitted within the time frames allowed will be evaluated by the grant review committee to determine which applicants' project plans will be submitted for CMS approval.

166.4(2) The department will submit the project plan for each grant the department intends to award, along with any required documentation, to CMS to seek approval or denial of the proposed project. All activities and plans for utilizing civil money penalty funds must be approved in advance by CMS.
[**ARC 0459D**, IAB 8/5/26, effective 10/1/26]

441—166.5(249A) Project contracts. Grants for approved applicant project plans will be awarded through a contract entered into by the department and the applicant. The contract period will not exceed the time frames allowed by state and federal laws. The department will reimburse expenditures pursuant to contract terms and the regular reimbursement procedures of the state of Iowa.
[**ARC 0459D**, IAB 8/5/26, effective 10/1/26]

These rules are intended to implement Iowa Code section 249A.57.

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CHAPTER 167
JUVENILE DETENTION REIMBURSEMENT
[Prior to 2/11/87, Human Services [498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/32

441—167.1(232) Definitions.

"Allowable costs" means those expenses of the county or multicounty related to the establishment, improvements, operation, and maintenance of county or multicounty juvenile detention homes.

"County or multicounty" means that the governing body is a county board of supervisors or a combination of members of participating county boards of supervisors.

"Detained" means the period of time a youth is physically occupying a bed in a juvenile detention home, that is, from the time of intake at the juvenile detention home (nothing prior to this) to the time a youth is discharged from the bed at the home (nothing after this).

"Eligible costs" are those allowable costs that are directly attributable to the function of detaining youth in the home, from the point of intake through discharge from the home.

"In-home detention" means a detention program that confines a child to the child's residence as an alternative to secure detention at a juvenile detention home. In-home detention allows limited movement for approved activities like school, work or medical appointments and aims to provide supervision of children while enabling them to maintain some responsibilities and relationships outside of a secure juvenile detention home.

[**ARC 0772D**, IAB 11/25/26, effective 1/1/27]

441—167.2(232) Availability of funds. Any year that the Iowa legislature makes funds available for this program, the department will accept requests for reimbursement from eligible facilities.

[**ARC 0772D**, IAB 11/25/26, effective 1/1/27]

441—167.3(232) Eligible detention homes. County and multicounty juvenile detention homes shall be eligible for reimbursement under this program when:

167.3(1) The home:

a. Is approved by the department under the standards of Iowa Code chapter 232.

b. Submits the following completed forms and audits by March 15, or within ten days of completion if after March 15, of the year following the conclusion of the state fiscal year for which reimbursement will be made.

(1) A written statement identifying the eligible total net cost that will be claimed.

(2) A copy of the department-authorized financial and statistical report for juvenile detention homes.

(3) A copy of the home's certified audit containing financial information for the period for which reimbursement is being claimed.

c. Has an independent certified public accountant or an independent accounting firm complete the financial and statistical report and certify the fair presentation of the report. The preparer shall have the experience necessary to complete the report in accordance with generally accepted accounting principles (GAAP) and the instructions for completing the financial and statistical report.

167.3(2) The department has reviewed the information submitted and determined that the costs to be claimed meet eligibility requirements. Eligible costs are based on the portions of the allowable costs that are directly attributable to the function of detaining youth in the home.

a. Costs are not eligible for reimbursement if a supplemental funding, reimbursement, or refund source is available to the home. County payments to an eligible home for the function of detaining youth in the home are not considered to be supplemental funding, reimbursement, or refund sources for the purpose of this subrule. Ineligible costs include but are not limited to:

(1) Refundable deposits.

(2) Services funded by sources other than the juvenile detention reimbursement program.

(3) Operational activities.

b. Costs attributed to portions of the home not directly used for detaining children.

c. Costs of alternatives to detaining youth in the approved detention home. Alternative services ineligible for reimbursement include but are not limited to:

(1) Community tracking and monitoring activities.

(2) Transportation during the time a youth is detained that is not related to service or care and keep or that is the responsibility of or funded by another source.

(3) Outreach services.

(4) In-home detention.

d. Capital expenses are depreciated over the useful life of the item following GAAP. The annual depreciated amount for items that are eligible costs may be claimed for reimbursement.

(1) Capital expenses include items costing more than $5,000 that have a useful life of over two years.

(2) Depreciation schedules shall be filed with the department annually.

[**ARC 0772D**, IAB 11/25/26, effective 1/1/27]

441—167.4(232) Available reimbursement. The reimbursement for the participating detention homes will be based on the distribution formula authorized by Iowa Code section 232.142.

[**ARC 0772D**, IAB 11/25/26, effective 1/1/27]

441—167.5(232) Reimbursement by the department. Reimbursement will only be made to those participating juvenile detention homes that the department has determined to have complied with these rules.

[**ARC 0772D**, IAB 11/25/26, effective 1/1/27]

These rules are intended to implement Iowa Code section 232.142.

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[Filed ARC 0772D (Notice ARC 0626D, IAB 9/30/26), IAB 11/25/26, effective 1/1/27]

CHAPTER 168
CHILD CARE EXPANSION PROGRAMS
[Prior to 6/28/89, see 441—Chapter 154]
Rescinded **ARC 6635C**, IAB 11/2/22, effective 1/1/23

CHAPTER 169
FUNDING FOR EMPOWERMENT AREAS
Rescinded **ARC 1444C**, IAB 4/30/14, effective 7/1/14

TITLE XV
INDIVIDUAL AND FAMILY SUPPORT
AND PROTECTIVE SERVICES

CHAPTER 170
CHILD CARE SERVICES

[Prior to 7/1/83, Social Services[770] Ch 132]
[Previously appeared as Ch 132—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/32

441—170.1(237A) Definitions.

"Child care" means the same as defined in Iowa Code section 237A.1.

"Child care facility" means the same as defined in Iowa Code section 237A.1.

"Child with protective needs" means a child who is in foster care or has a case file that identifies child care as a safety or well-being need to prevent or alleviate the effects of child abuse or neglect. Child care is provided as part of a safety plan during a child abuse or child in need of assistance assessment or as part of the service plan established in the family's case plan. This designation means that the child has at least one of the following:

1. An open child abuse assessment;
2. An open child in need of assistance assessment;
3. An open child welfare case as a result of a child abuse assessment;
4. A petition on file for a child in need of assistance adjudication; or
5. Adjudication as a child in need of assistance.

"Client" means a current or former recipient of the child care assistance program.

"Client error" means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances that affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances that affect eligibility or the amount of assistance received;
3. Failure to timely report the receipt of child care units in excess of the number approved by the department;
4. Failure to comply with the need for service requirements.

"Department error" means child care assistance incorrectly paid for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Loss or misfiling of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make timely changes in assistance following amendments of policies that require the changes by a specific date.

"Food services" means the preparation and serving of nutritionally balanced meals and snacks.

"Intentional program violation" means and may result from knowingly making or causing to be made a false statement or a misrepresentation of a material fact, failing to disclose a material fact, or committing a fraudulent practice to receive benefits in an amount greater than the amount the client or provider is entitled to receive.

"In-home" means care that is provided within the child's own home.

"Net profit from self-employment" means gross income less the costs of producing the income other than depreciation. A net loss in self-employment income cannot be offset from other earned or unearned income.

"Overpayment" means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

"Parent" means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

"Program and activities" means the daily schedule of experiences in a child care setting.

"PROMISE JOBS" means the department's work and training program, promoting independence and self-sufficiency through employment job opportunities and basic skills as described in 441—Chapter 93.

"Provider" means a licensed child care center, a registered child development home, a caretaker who provides care for a child in the child's home, or a nonregistered child care home.

"Provider error" means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;
2. Submitting false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;
4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services;
5. Failure to maintain a copy of attendance records signed by the parent and the provider.

"Recoupment" means the repayment of an overpayment by the client or provider or both.

"Signature" means a person's name written in a distinctive way as a form of identification and will include but not be limited to wet ink signatures and electronic verification options such as picture/face recognition, PIN entry, digital fingerprint, biometric verification, or electronic signature that is unique to the person signing.

"Special needs child" means the same as defined in Iowa Code section 237A.1.

"Supervision" means the care, protection, and guidance of a child.

"Timely" means within ten calendar days.

"Unit(s) of service" means a half day that will be up to 5 hours of service per 24-hour period.

"Vocational training or education" means a training plan that includes a specific goal; that is, high school completion, high school equivalency, improved English skills, or development of specific academic or vocational skills.

[**ARC 0773D**, IAB 11/25/26, effective 1/1/27]

441—170.2(237A,239B) Eligibility requirements. A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including but not limited to provider requirements under Iowa Code chapter 237A and provider reimbursement methodology. The department will determine the number of units of service to be approved.

170.2(1) *Financial eligibility.* Financial eligibility for child care assistance will be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa's median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes will go into effect for the child care assistance program on July 1 of each year.

a. Income limits.

(1) For initial eligibility, an applicant family's nonexempt gross monthly income cannot exceed the amounts as described in Iowa Code section 237A.13(2).

(2) For ongoing eligibility, at the time of a family's annual eligibility redetermination, if the family's nonexempt gross monthly income exceeds the amounts in subparagraph 170.2(1)*"a"*(1), the family may continue to be eligible as long as the family's nonexempt gross monthly income does not exceed the amounts in this subparagraph.

1. 225 percent of the federal poverty level applicable to the family size for children needing basic care or special-needs care; or
2. 85 percent of Iowa's median family income, if that figure is lower than the standard in numbered paragraph 170.2(1)*"a"*(2)"1."

(3) For ongoing eligibility, at the time of a family's annual eligibility redetermination, if the family's nonexempt gross monthly income exceeds the amounts in subparagraphs 170.2(1)*"a"*(1) and *"a"*(2), the family may continue to be eligible as long as the family's nonexempt gross monthly income does not exceed the amounts as described in Iowa Code section 237A.14(1).

b. Exceptions to income limits. Exception to income limits can be made under certain circumstances:

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) A person who is employed by a child care facility or child care home that is accepting child care assistance and who is eligible under Iowa Code section 237A.13A as enacted by 2026 Iowa Acts, House File 2514, is eligible for child care assistance without regard to income if there is a need for child care services. The family will be assigned a copay as specified by the department based on the family's nonexempt gross monthly income.

(4) Protective child care services are provided without regard to income.

(5) Child care services for licensed foster parents who need child care for foster children are provided without regard to income.

(6) In certain cases, the department will provide child care services as directed in a court order.

c. Determining gross income. Eligibility will be determined using a projection of income based on the best estimate of future income. In determining a family's gross monthly income, the department will consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income unless excluded under paragraph 170.2(1)*"d."*

(1) Income considered will include wages or salary, net profit from self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers' compensation, alimony, child support, veterans pensions, cash payments, casino profits, railroad retirement, permanent disability insurance, strike pay, and living allowance payments made to participants of the AmeriCorps program.

(2) Income will be projected using gross income received in the previous 30-day period or an average of the income from a longer period of time if indicative of future income.

(3) Anticipated changes to future income will be considered for new employment using an employer statement of earnings or other verification from the income source.

(4) For seasonal workers, the monthly gross income will be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

d. Income exclusions. The following sources are excluded from the computation of monthly gross income:

(1) Money received from the sale of property unless the person was engaged in the business of selling property.

(2) Withdrawals of bank deposits.

(3) Money borrowed.

(4) Tax refunds.

(5) Federal or state earned income tax credit.

(6) Reimbursement from the employer for job-related expenses.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the Supplemental Nutrition Assistance Program (SNAP) allotment under the Food and Nutrition Act of 2008 as amended to August 1, 2026.

(11) The value of USDA-donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 as amended to August 1, 2026, and the special food program for children under the National School Lunch Act as amended to August 1, 2026.

(13) Earnings of a minor unless the minor is the parent on the application.

(14) The income of the parents with whom a teen parent resides.

(15) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(16) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act as amended to August 1, 2026.

(17) Stipends received for participating in the foster grandparent program.

(18) Payments from the subsidized guardianship waiver program.

(19) Any adoption subsidy payments received from the department.

(20) Payments from the federal Low-Income Home Energy Assistance Program (LIHEAP).

(21) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(22) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(23) Payments from the transition to independence program (TIP).

(24) Stipends from the preparation for adult living (PAL) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

(27) Census earnings received by temporary workers from the Bureau of the Census.

(28) Payments from the Iowa individual assistance grant program (IIAGP).

(29) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(30) Payments made pursuant to Real Estate Settlement Procedures Act (RESPA) as amended to August 1, 2026, to the extent the payments are exempt from taxation.

(31) Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended to August 1, 2026, and, the Disaster Relief and Emergency Assistance Amendments of 1988 as amended to August 1, 2026.

e. Family size. The following people shall be included in the family size for the determination of eligibility:

(1) Legal spouses who reside in the same household.

(2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.

(3) A child or children who live with a person or persons not legally responsible for the child's support.

f. Effect of temporary absence. The composition of the family does not change when a family member is temporarily absent from the household. A family member may be absent from the home temporarily for the following reasons:

(1) An absence for the purpose of education or employment.

(2) An absence due to medical reasons that is anticipated to last less than three months.

(3) Any absence when the person intends to return home within three months.

g. Resource limits. For initial and ongoing eligibility, family resources cannot exceed $1 million.

170.2(2) *General eligibility requirements.* In addition to meeting financial requirements, the child needing services must meet age, residency, and citizenship requirements. Each parent in the household must have at least one need for service and shall cooperate with the department's quality control review and with investigations conducted by the department of inspections, appeals, and licensing.

a. Age. Child care will be provided only to children up to age 13, unless the child is a special needs child, in which case child care will be provided up to age 19. When a child reaches the age of 13 or,

as applicable, the age of 19, during the certification period, eligibility will continue until the end of the approved certification period.

b. Residency. To be eligible for child care services, the person must be living in the state of Iowa. Residency will include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

c. Citizenship. As a condition of eligibility, the applicant shall attest to the child's citizenship or alien status by signing the Child Care Assistance Application form. Child care assistance payments may be made only for a child who:

(1) Is a citizen or national of the United States; or

(2) Is a qualified alien as defined at 8 U.S.C. Section 1641 as amended to August 1, 2026.

1. The applicant shall furnish documentation of the alien status of any child declared to be a qualified alien.

2. A child who is a qualified alien is not eligible for child care assistance for a period of five years beginning on the date of the child's entry into the United States with qualified alien status. The five-year prohibition from receiving assistance does not apply to qualified aliens described at 8 U.S.C. Section 1613 as amended to August 1, 2026.

d. Need for service. Assistance will be provided to a two-parent family only during the parents' coinciding hours of participation in training, employment, or job search. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training in full-time status. Child care services may be provided for the parent's hours of participation in academic or vocational training and for actual travel time between the child care location and the training facility.

1. Child care provided while the parent participates in postsecondary education leading up to a baccalaureate degree program or vocational training will be limited to a 24-month lifetime limit. PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training will count toward the 24-month lifetime limit.

2. Payment will not be approved for child-care during training in the following circumstances:

- The training is for jobs paying less than minimum wage.
- A parent who possesses a baccalaureate degree wants to take additional college coursework unless the coursework is to obtain a teaching certificate or complete continuing education units.
- The course or training is one that the parent has previously completed.
- The parent wants to participate in online or distance learning from the parent's own home, and the training facility does not require specified hours of attendance.

(2) The parent is employed an average of 32 or more hours per week (28 hours per week if the family includes a special needs child) during the month. Child care services may be provided for the hours of employment, or for sleep time during daytime hours, and for actual travel time between the child care location and the place of employment.

(3) The parent has a child with protective needs for child care. The department will determine the hours of need for a child with protective needs, regardless of the parent's hours of participation in training, employment, or job search. The child welfare case file will document the eligibility for service of the child with protective needs.

(4) The parent is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but due to medical incapacity is unable to care for the child or participate in work or training, as verified by a physician. Eligibility under this paragraph is limited to parents who become temporarily medically incapacitated, or to instances of one parent in a two-parent household being permanently disabled, while eligible for child care assistance based on the need criteria in subparagraph 170.2(2)*"d"*(1) or *"d"*(2).

1. Child care assistance will continue to be available through the authorized certification period after the parent becomes temporarily medically incapacitated.

2. The number of units of service authorized will be determined as follows:

- For a single-parent family, the number of units authorized for the period of incapacity will not exceed the number of units authorized for the family before the onset of incapacity.
- For a two-parent family where one parent is temporarily or permanently incapacitated, the units of service authorized will be based on the need of the parent who is not incapacitated.

(5) The parent is looking for employment. Child care for job search hours will be limited to only those hours the parent is actually looking for employment, including travel time. Job search will be limited to a maximum of 90 consecutive days.

1. For applicants, job searching will be approved for a maximum of 90 consecutive days. If the parent has not started employment within 90 days, assistance will be canceled.
2. For ongoing participants, job search will be limited to a maximum of 90 consecutive days.

(6) The parent needs child care services due to participation in activities approved under the PROMISE JOBS program.

(7) The family is part of the family investment program and there is a need for child care services due to employment or participation in vocational training or education. A family who meets this requirement due to employment is not required to work a minimum number of hours. If a parent in a family investment program household remains in the home, child care assistance can be paid if that parent receives supplemental security income.

(8) The parent is employed and participating in academic or vocational training for an average of 32 or more hours per week (28 hours per week if the family includes a special needs child) during the month.

(9) Family eligibility will continue during an approved certification period when a temporary lapse in need for service for a parent occurs. A temporary lapse in a parent's need for service is allowed when a time-limited absence from work, training or education program occurs due to:

1. Need to care for a family member.
2. An illness.
3. Maternity leave.
4. Family Medical Leave Act (FMLA) as amended to August 1, 2026, situations for household members.
5. Participation in a treatment/rehabilitation program.
6. Any reduction in employment or vocational training or education hours that fall below the minimum number set forth in subparagraph 170.2(2)*"d"*(1), *"d"*(2) or *"d"*(8) as long as the parent continues to work or attend training or education.
7. Any student holiday or break for a parent participating in training or education.
8. Any interruption in work for a seasonal worker who is not working between regular industry work seasons.

(10) Family eligibility will be canceled if the lapse in need is not temporary because the lapse will continue with no established end date.

e. Cooperation. Parents shall cooperate with the department when the department selects the family's case for quality control review to verify eligibility. Parents shall also cooperate with investigations conducted by the department of inspections, appeals, and licensing to determine whether information supplied by the parent regarding eligibility for child care assistance is complete and correct.

(1) Failure to cooperate will serve as a basis for cancellation or denial of the family's child care assistance.

(2) Once assistance is denied or canceled for failure to cooperate, the family may reapply but will not be considered for approval until cooperation occurs.

170.2(3) *Priority for assistance.* Child care services will be provided only when funds are available. Funds available for child care assistance will first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs or licensed foster parents who need child care for foster children. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

a. Priority groups. Priority groups will be determined according to Iowa Code section 237A.13(9).

b. Exceptions to priority groups. The following are eligible for child care assistance and will not be prevented from receiving benefits by waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families who receive a state adoption subsidy for a child.

(4) Families who are experiencing homelessness.

(5) Licensed foster parents who need child care for foster children.

c. Effect on need for service. Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2)*"d,"* except at review or redetermination.

170.2(4) *Reporting changes.* The parent may report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the department worker or the PROMISE JOBS worker within ten calendar days of the change.

a. Timely reporting. If the change is timely reported, the effective date of the change will be the date when the change occurred.

b. Non-timely reporting. If the change is not timely reported, the effective date of the change will be the date when the change is reported to the department office or the PROMISE JOBS office.

c. Exceptions. The following changes must be reported:

(1) Changes in income when the family's gross monthly income exceeds 85 percent of Iowa's median family income.

(2) A lapse in a parent's need for service that is not temporary.

(3) A change in residency outside of the state of Iowa.

(4) No eligible child remains in the home.

d. Changes not required to report. The department will disregard any reported changes that are not required to be reported unless the change would cause the authorized units to be increased or the family copay amount to be decreased.

[**ARC 0773D**, IAB 11/25/26, effective 1/1/27]

441—170.3(237A,239B) Application and determination of eligibility.

170.3(1) *Application process.* Application for child care assistance may be made online using the electronic application available on the family portal, at any local office of the department, or by mailing an application to the department.

a. At the end of a certification period, ongoing eligibility is determined by completing the Child Care Assistance Review form.

b. The application may be filed by the applicant; by the applicant's authorized representative; or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

c. The date of application is the date a signed application form containing a legible name and address is received by the department. An electronic or paper application delivered to a closed office is considered to be received on the first day following the day the office was last open that is not a weekend or state holiday.

d. Families who are determined eligible for child care assistance will be approved for a certification period of at least 12 months. Families who fail to complete the review and redetermination process will lose eligibility at the end of the certification period.

170.3(2) *Exceptions to application requirement.* An application is not required for:

a. A person who is participating in activities approved under the PROMISE JOBS program.

b. Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients. The date of application is the date the family requests child care assistance from the department.

c. Children with protective needs.

d. Licensed foster parents who need child care for foster children.

e. Child care services provided under a court order.

170.3(3) *Application processing.* The department will promptly approve or deny an application based on priority groups and the date the application was received.

a. The department, or PROMISE JOBS program as applicable, will determine the number of units of service authorized for each eligible family and will:

(1) Inform the family through the notice of decision; and

(2) Inform the family's provider through the Certificate of Enrollment form.

b. Unless a provider or applicant indicates otherwise, delivery of notice shall be effectuated through electronic means.

c. The effective date of assistance will be the date of application or the date the need for service began, whichever is later. When an application is not required, the effective date will be as follows:

(1) For a person participating in activities under the PROMISE JOBS program, the effective date of child care assistance will be the date the person becomes a PROMISE JOBS participant or the date the person has a need for child care assistance to participate in an approved PROMISE JOBS activity as described in 441—Chapter 93, whichever is later.

(2) For a family receiving family investment program benefits, the effective date of child care assistance will be no earlier than the effective date of family investment program benefits, 30 days before the date of application for child care assistance, or the date the need for service began, whichever is the latest.

(3) For a family with protective service needs, the effective date of assistance will be the date the family signs the Application for All Social Services form.

(4) When child care services are provided under a court order, the effective date of assistance will be the date specified in the court order or the date of the court order if no date is specified.

(5) For a family whose application was denied for failure to provide requested information but who provides all information necessary to determine eligibility, including verification of all changes in circumstances, within 14 days of the denial, the effective date of assistance will be the date that all information required to establish eligibility is provided. If the fourteenth calendar day falls on a weekend or state holiday, the family will have until the next business day to provide the information.

170.3(4) *Waiting lists for child care services.*

a. When the department has determined that there may be insufficient funding, applications for child care assistance will be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

b. When the department determines that there is adequate funding, the department will notify the public regarding the availability of funds.

170.3(5) *Review and redetermination.* The department will redetermine a family's financial and general eligibility for child care assistance no sooner than 12 months following the initial determination or most recent redetermination.

a. The department will use information gathered on the Child Care Assistance Review form to redetermine eligibility, except when the family is not required to complete a review form as provided in paragraph 170.3(5)*"b."*

(1) If the family does not return a complete review form to the department by the end of the certification period, the family must reapply for benefits, except as provided in paragraph 170.3(6)*"a."* A returned Child Care Assistance Review form is complete when all items are answered, the form is signed and dated by the applicant, and is accompanied by all verification needed to determine continued eligibility.

(2) The department will redetermine only general eligibility for recipients eligible under paragraph 170.2(1)*"b."*

(3) If eligibility under paragraph 170.2(1)*"b"* ends, the department will redetermine financial and general eligibility for child care assistance. The redetermination of eligibility will be completed within 30 days.

b. Families who have children with protective needs, licensed foster parents who need child care for foster children, and families who are receiving child care assistance because the parent is participating in activities under the PROMISE JOBS program are not required to complete the Child Care Assistance Review form. The department will gather information needed to redetermine general eligibility. If the department needs information from the family, the department will send a written request to the family. If

the family does not return the requested information by the due date, the family must reapply for child care assistance, except as provided in paragraph 170.3(6)*"a."*

170.3(6) *Reinstatement.* Assistance will be reinstated without a new application when all necessary information is provided before the effective date of expiration or cancellation and eligibility can be reestablished. If there is a change in circumstances, the change must be verified before the case will be reinstated.

a. Grace period. Assistance will be reinstated without a new application when all information necessary to determine eligibility, including verification of all changes in circumstances, is provided within 14 calendar days of the effective date of expiration or cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the family will have until the next business day to provide the information. The effective date of child care assistance will be the date that all information required to establish eligibility is provided.

b. Denial. Child care assistance will be denied when the department determines that:

(1) The client is not in need of service;

(2) The client is not financially eligible;

(3) There is another resource available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers;

(4) Funding is not available;

(5) An application is required and the client or representative refuses or fails to sign the application form;

(6) The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources. Signing a general authorization for release of information to the department does not meet this responsibility; or

(7) The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections, appeals, and licensing.

c. Termination. Child care assistance may be terminated when the department determines that:

(1) The client no longer meets the eligibility criteria in subrule 170.2(2);

(2) The client's income exceeds the financial guidelines;

(3) Another resource is available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers;

(4) Funding is not available;

(5) The client makes a false or misleading statement, misrepresents, conceals, or withholds facts;

(6) The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources; or

(7) The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections, appeals, and licensing.

[**ARC 0773D**, IAB 11/25/26, effective 1/1/27]

441—170.4(237A) Elements of service provision.

170.4(1) *Fees.* Fees for services received will be charged to clients according to the schedules in this subrule, except that fees will not be charged to clients receiving services without regard to income.

a. Sliding fee schedule.

(1) For families whose eligibility is established in subparagraphs 170.2(1)*"a"*(1) and *"a"*(2), the child care assistance and child care assistance plus programs fee schedule, dated July 2026, found on the department's website is effective for eligibility determinations made on or after July 1, 2026. The fee is a per-unit charge that is applied to the child in the family who receives the largest number of units of service. The fee will be charged for only one child in the family, regardless of how many children receive assistance.

(2) For families whose eligibility is established in subparagraph 170.2(1)*"a"*(3), the child care assistance exit program fee schedule, dated July 2026, found on the department's website is effective for eligibility determinations made on or after July 1, 2026. The fee is a percentage of the cost of child care for each child in the family who receives service.

b. Collection. The provider will collect fees from clients and maintain records of fees collected. These records will be available for audit by the department.

c. Inability of client to pay fees. Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the department will assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee will then be charged for the remainder of the certification period. Reduced fees may be justified by:

(1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.

(2) Shelter costs that exceed 30 percent of the household income.

(3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.

170.4(2) *Method of provision.* Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)*"d"*(3), as long as the conditions in paragraph 170.4(7)*"d"* are met. When the child meets the need for service under subparagraph 170.2(2)*"d"*(3), parents shall be allowed to exercise their choice of licensed, registered, or non-registered child care provider, except when the department determines it is not in the best interest of the child. The provider must meet one of the applicable requirements set forth in this subrule.

a. Licensed child care center. A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License form.

b. Registered child development home. A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Child Care Home Registration form.

c. Non-registered child care home. A non-registered child care home shall have an approved Payment Application form and a current Child Care Assistance Provider Agreement with the department. Non-registered child care homes are required to meet minimum health and safety standards as set forth in 441—Chapter 110.

d. In-home care. In-home providers who provide care for the child in the family home must sign the Payment Application for Non-registered Providers and Child Care Assistance Provider Agreement forms. In-home providers must meet the following components as set forth in:

(1) 441—paragraph 110.10(1)*"a,"* professional development for preservice training;

(2) 441—paragraph 110.10(1)*"b,"* professional development for mandatory reporting of child abuse;

(3) 441—paragraph 110.10(1)*"c,"* professional development for first-aid and cardiopulmonary resuscitation (CPR) training; and

(4) 441—subrule 110.11(3), record checks.

e. Out-of-state provider. A child care provider who is not located in Iowa may be selected by the parent so long as the out-of-state child care provider verifies that the provider meets the licensing requirements to be a provider in the state in which the provider operates.

170.4(3) *Components of service program.* Every child eligible for child care services will receive supervision, food services, and programs and activities, and may receive transportation.

170.4(4) *Payment.* The department will make payment for child care provided to an eligible family when the family reports their choice of provider to the department and the provider has an approved Child Care Assistance Provider Agreement form on file.

a. Rate of payment. The rate of payment for child care services, except for in-home care, which will be paid in accordance with paragraph 170.4(4)*"d,"* will be the actual rate charged by the provider for a private individual, not to exceed the maximum rates applicable to the provider type and age group as shown below.

(1) Half-day rates are calculated by dividing the provider's weekly rate from the Child Care Assistance Provider Agreement form by five to get the daily rate and then dividing this daily amount by two to get the half-day rate.

(2) To be eligible for the special-needs rate, the parent must submit documentation to the department that the child needing services has been assessed by a qualified professional and meets the definition for a "special needs child," and the provider must submit documentation to the department of the support being

provided based on the description of the child's special needs, including adaptive equipment, more careful supervision, or special staff training.

Table 1
Half-Day Rate Ceilings for (Licensed Center)

	No Quality Rating		Quality Rating 1 or 2		Quality Rating 3 or 4		Quality Rating 5	
Age Group	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	$25.66	$51.94	$25.66	$51.94	$25.66	$51.94	$27.00	$51.94
Preschool	$19.50	$30.43	$20.25	$30.43	$21.50	$30.43	$22.97	$30.43
School Age	$16.50	$30.34	$17.10	$30.34	$17.50	$30.34	$18.50	$30.34

Table 2
Half-Day Rate Ceilings for (Child Development Home A/B)

	No Quality Rating		Quality Rating 1 or 2		Quality Rating 3 or 4		Quality Rating 5	
Age Group	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	$16.63	$24.95	$16.63	$24.95	$16.63	$24.95	$17.50	$26.25
Preschool	$15.00	$22.50	$15.50	$23.25	$16.00	$24.00	$17.00	$25.50
School Age	$15.00	$22.50	$15.25	$22.88	$15.50	$23.25	$15.75	$23.63

Table 3
Half-Day Rate Ceilings for (Child Development Home C)

	No Quality Rating		Quality Rating 1 or 2		Quality Rating 3 or 4		Quality Rating 5	
Age Group	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	$18.00	$27.00	$18.00	$27.00	$18.00	$27.00	$18.50	$27.75
Preschool	$16.28	$24.42	$17.00	$25.50	$17.50	$26.25	$18.50	$27.75
School Age	$15.00	$22.50	$15.75	$23.63	$16.44	$24.66	$17.50	$26.25

Table 4
Half-Day Rate Ceilings for Child Care Home (Not Registered)

Age Group	Basic	Special Needs
Infant and Toddler	$16.63	$24.95
Preschool	$15.00	$22.50
School Age	$15.00	$22.50

b. The following definitions apply in the use of the rate tables:

(1) "Licensed center" means those providers as detailed in 170.4(2)*"a."*

(2) "Child development home A/B" or "child development home C" means those providers as defined in paragraph 170.4(2)*"b."*

(3) Under age group, "infant and toddler" means age two weeks to three years.

(4) "Preschool" means three years to school age.

(5) "School age" means a child in attendance in full-day or half-day classes.

(6) A child care facility that is rated under the quality rating system will be paid according to the corresponding quality rating payment level in the tables above only during the period the rating is valid as defined in 441—Chapter 118. If the child care facility does not have a quality rating or its quality rating expires, the child care facility will be paid according to the "no quality rating" payment level. A child care facility whose quality rating has expired will not receive backdated payments once a new rating is awarded.

(7) For a child care facility rated "quality rating 5," if a renewal application is received before the current rating period expires, the child care facility will continue to be paid according to the "quality rating 5" payment level until a decision is made on the IQ4K application.

c. Payment for days of absence. Payment may be made to a child care provider for an individual child not in attendance at a child care facility or home not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

d. Payment for in-home care. Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care will be the state's minimum wage amount.

e. Limitations on payment. Payment will not be made for therapeutic services that are provided in the care setting and include but are not limited to services such as speech, hearing, physical and other therapies; individual or group counseling; therapeutic recreation; and crisis intervention. Payment will not be made for educational services that are provided in the care setting and include but are not limited to services such as private tutoring and homeschool instruction.

f. Review of the calculation of the rate of payment. Maximum rate ceilings cannot be appealed. A provider who is in disagreement with the calculation of the half-day rate as set forth in paragraph 170.4(4) *"a"* may request a review within 15 calendar days of notification of the rate in question. The department will provide a written response within 15 calendar days of receipt of the request for review.

g. Submission of claims. The department will issue payment when the provider submits correctly completed documentation of attendance and charges. The department will pay for no more than the number of units of service authorized in the notice of decision issued.

(1) Providers shall submit documentation of attendance and charges within six months of the care being provided. Submission of claims older than six months are subject to special review and may be rejected.

(2) The provider shall keep the attendance records for a period of five years after the billing date.

(3) Providers shall submit a claim in one of the following ways:

1. Using the Child Care Assistance Billing/Attendance form, or

2. Using an electronic request for payment submitted through the provider portal or other approved child care management system. Providers using an electronic method shall ensure attendance records include the child's name, the dates, the daily time in and time out entries for days the child was in care, and the signature of the parent or other designee certifying the attendance is accurate.

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441—170.5(237A) Adverse actions.

170.5(1) *Provider agreement.* The department may refuse to enter into or may revoke a child care assistance provider agreement if any of the following occur:

a. The department finds the provider is not following the minimum health and safety regulatory requirements as set forth in 441—Chapters 109 and 110.

b. The provider has submitted claims for payment for which the provider is not entitled.

c. The provider fails to cooperate with an investigation conducted by the department of inspections, appeals, and licensing to determine whether information the provider supplied to the department regarding payment for child care services is complete and correct. Once the agreement is revoked for failure to cooperate, the department will not enter into a new agreement with the provider until cooperation occurs.

d. The provider does not meet one of the applicable requirements set forth in subrule 170.4(2).

e. The provider fails to comply with any of the terms and conditions of the department.

f. An overpayment of funds with a balance of $3,000 or more exists for a provider and that provider fails to enter into a repayment agreement with the department of inspections, appeals, and licensing or does not make payments according to the repayment agreement on file.

170.5(2) *Provider agreement sanction.* If the provider agreement is terminated for any of the reasons in subrule 170.5(1), the agreement will remain terminated for the time periods set forth below:

a. The first time the agreement is terminated, the provider may reapply for another agreement at any time.

b. The second time the agreement is terminated, the provider cannot reapply for another agreement for 12 months from the effective date of termination.

c. The third or subsequent time the agreement is terminated, the provider cannot reapply for another agreement for 36 months from the effective date of termination.

d. The department will not act on an application for a child care assistance provider agreement submitted by a provider during the sanction period.

e. The department is not required to approve an application submitted by a provider following the sanction period. When the provider has an overpayment on record, evidence of an active payment agreement and payments made will be taken into consideration.

170.5(3) *Client child care assistance benefits sanction.* If child care assistance is terminated for any of the reasons in subparagraphs 170.3(6)*"c"*(5) through *"c"*(7), the case will remain terminated for the time periods set forth below:

a. The first time the case is terminated, the client may submit a new application for assistance at any time.

b. The second time the case is terminated, the client cannot reapply for 12 months from the effective date of termination.

c. The third time the case is terminated, the client cannot reapply for 36 months from the effective date of termination.

d. The department will not act on an application for child care assistance submitted by a client during the sanction period.

e. The department is not required to approve an application submitted by a client following the sanction period. When the client has an overpayment on record, evidence of an active payment agreement and payments made will be taken into consideration.

[**ARC 0773D**, IAB 11/25/26, effective 1/1/27]

441—170.6(237A) Appeals. Notice of adverse action will be given in accordance with 441—Chapter 16. The right to appeal will be given in accordance with 441—Chapter 2506.

[**ARC 0773D**, IAB 11/25/26, effective 1/1/27]

441—170.7(237A) Provider fraud.

170.7(1) *Fraud.* The department will consider a child care provider to have committed fraud when an intentional program violation results in:

a. The department of inspections, appeals, and licensing finds in an administrative or judicial proceeding a provider to have obtained child care assistance payment(s) for which the provider was not eligible in an amount in excess of $1,000; or

b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained child care assistance payment in an amount in excess of $1,000 for which the provider was not eligible.

170.7(2) *Potential provider sanctions.* Potential sanctions are set forth in Iowa Code section 237A.29.

170.7(3) *Factors considered in determining level of sanction.* The department will consider factors in determining the sanction(s) to be imposed according to Iowa Code section 237A.29(2)*"c."*

170.7(4) *Mitigating factors.* If the sanction determined according to subrule 170.7(2) is suspension from or ineligibility for receipt of child care assistance payment, the department will determine whether it is appropriate to reduce the level of a sanction for the particular case, considering:

a. Prior provision of provider education.

b. Provider willingness to obey program rules.

c. A lesser sanction will be sufficient to resolve the violation.

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441—170.8(237A) Client fraud.

170.8(1) *Program violation.* An individual who is found by the department of inspections, appeals, and licensing in an administrative proceeding, or by a court in a judicial proceeding, to have committed an intentional program violation or has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the individual has committed an intentional program violation, is disqualified from receiving the child care assistance benefits. If an individual is found to have committed

an intentional program violation, a sanction must be imposed on the individual found to have committed the intentional program violation and the household as set forth in 45 CFR Section 98.68(b)(2) as amended to August 1, 2026. The sanction will be determined by the department after the administrative or judicial proceeding or without a hearing if the individual waives the right to a hearing by agreement to entry of a civil judgment or judgment by confession.

170.8(2) *Potential client sanctions resulting from fraud.* The period of disqualification is:

a. For a first violation, the individual is disqualified for one year;

b. For a second violation, the individual is disqualified for two years; and

c. For a third violation, the individual is permanently disqualified.

[**ARC 0773D**, IAB 11/25/26, effective 1/1/27]

441—170.9(237A) Child care assistance overpayments. All child care assistance overpayments will be subject to recoupment.

170.9(1) *Notification and appeals.* All clients or providers will be notified when it is determined that an overpayment exists. Notification will include the amount of, date of, and reason for the overpayment. The department will provide additional information regarding the computation of the overpayment upon the client's or provider's request. The client or provider may appeal the computation of the overpayment and any action to recover the overpayment in accordance with 441—Chapter 2506.

170.9(2) *Determination of overpayments.* All overpayments due to client, provider, or department error or due to benefits or payments issued pending an appeal decision will be recouped. Recoupment of overpayments resulting from benefits or payments issued pending a decision on an appeal hearing will not occur until after a final appeal decision is issued and the department prevails. Overpayments will be computed as if the information had been acted upon timely.

170.9(3) *Failure to cooperate.* Failure by the client to cooperate in the investigation of alleged overpayments will result in ineligibility for the months in question and the overpayment will be the total amount of assistance received during those months. Failure by the provider to cooperate in the investigation of alleged overpayments will result in payments being recouped for the months in question.

170.9(4) *Payment agreement.* The client or provider may choose to make a lump-sum payment or make periodic installment payments as agreed to with the department. Failure to negotiate an approved payment agreement may result in further collection action.

170.9(5) *Procedures for recoupment.*

a. When the department determines that an overpayment exists, the department will submit the case to the department of inspections, appeals, and licensing for investigation, recoupment, or referral for possible prosecution.

b. The department of inspections, appeals, and licensing will initiate recoupment by notifying the debtor of the overpayment.

c. When financial circumstances change, the department of inspections, appeals, and licensing has the authority to revise the recoupment plan.

d. Recoupment for overpayments due to client error or due to department error that affected eligibility will be made from the parent who received child care assistance at the time the overpayment occurred. When two parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

e. Recoupment for overpayments due to provider error or due to department error that affected benefits will be made from the provider.

f. Recoupment for overpayments caused by both the provider and client will be collected from both the provider and client equally.

170.9(6) *Suspension and waiver.* Recoupment will be suspended on non-fraud overpayments when the amount of the overpayment is less than $35. Recoupment will be waived on non-fraud overpayments of less than $35 that have been held in suspense for three years.

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CHAPTER 171
ADULT DAY CARE
Rescinded IAB 3/6/02, effective 5/1/02

CHAPTER 172
FAMILY-CENTERED SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 12/1/31

441—172.1(234) Definitions.

"Case" means at least one child in a household is involved in department services with a department social work case manager.

"Child" or *"children"* means a person or persons who meet the definition of a child in Iowa Code section 232.68(1).

"Child abuse" means one or more of the categories of child abuse defined in Iowa Code section 232.68(2).

"Child abuse assessment" means an assessment process by which the department responds to all accepted reports that allege child abuse as defined in Iowa Code section 232.68(2), or that allege child abuse as defined in Iowa Code section 232.68(2) that also allege imminent danger, death, or injury to a child. A child abuse assessment results in a disposition and a determination of whether a case meets the definition of child abuse and a determination of whether criteria for placement on the registry are met.

"Child in need of assistance" means the same as set forth in Iowa Code section 232.2(8).

"Contractor" means a private organization authorized to do business in Iowa that has entered into a contract with the department to provide one or more of the services defined in Iowa Code section 232.102A(2)*"b."*

"Family-centered services" means the services provided by contract pursuant to Iowa Code section 232.102A(2)*"b."*

"Family risk assessment" means the assessment of probability or likelihood a child will suffer maltreatment in the future.

"Household" means the place where a child resides.

"Kinship foster caregiver" means the same as set forth in 441—Chapter 125.

"Permanency" means a child has a safe, stable, custodial environment in which to grow up and a lifelong relationship with a nurturing caregiver.

"Protective capacities" means the family strengths or resources that reduce, control, or prevent risks from arising or from having an unsafe impact on a child.

"Risk" means the probability or likelihood that a child will experience maltreatment.

"Safe" or *"safety"* means that no signs of present or impending danger to a child are identified or that one or more signs of present or impending danger are identified but the child's degree of vulnerability or the caregiver's protective capacities offset the current threat. The child is not likely to be in imminent danger of maltreatment.

[**ARC 0672D**, IAB 10/14/26, effective 12/1/26]

441—172.2(234) Family-centered services. Family-centered services are services designed to prevent the child from entering foster care and to assist the family when the needs of the child, parent, or kinship foster caregiver are directly related to the safety, permanency, or well-being of the child. The outcome of the services may be to maintain the child with a parent or in the home of the kinship foster caregiver, to reunify the child safely with a parent or kinship foster caregiver, or to achieve permanent family connections for the child.

172.2(1) Family-centered services provide interventions and supports based on identified needs of children and families that have come to the department's attention because of:

a. Evaluation of a child abuse assessment or child in need of assistance assessment and the family's risk assessment score; or

b. The child's adjudication as a child in need of assistance pursuant to Iowa Code section 232.2; or

c. The child's placement out of home under the department's care and supervision.

172.2(2) Family-centered services are designed to:

a. Identify and build on the family's strengths and enhance the family's protective capacities;

b. Address the risk factors that affect the child's safety, permanency, and well-being; and

c. Strengthen family connections to community resources and informal support systems in order to promote greater self-reliance.

172.2(3) Family-centered services will utilize evidence-based interventions to the greatest possible extent.

172.2(4) Family-centered services may be offered to the following persons:

a. A child eligible for services under the provisions laid out in this rule;

b. Any sibling of that child who resides in the same household at the time of service referral or moves into the household during the service delivery period; and

c. A parent, stepparent, or kinship foster caregiver of the child.

172.2(5) During the time that a child and the child's family are approved to receive family-centered services on an open case, the department will be responsible for maintaining case management, including contact with the child and family to ensure that:

a. The factors that present risks of harm to the safety and well-being of all children in the family are being adequately addressed; and

b. Services and supports are in place to achieve the child's permanency goal.

[**ARC 0672D**, IAB 10/14/26, effective 12/1/26]

441—172.3(234) Authorization. When the department has approved provision of family-centered services for a child and family, the department will notify the contractor by issuing the referral and authorization for child welfare services form. This authorization form will indicate:

172.3(1) The specific service category authorized; and

172.3(2) The duration of the authorization.

[**ARC 0672D**, IAB 10/14/26, effective 12/1/26]

441—172.4(234) Client appeals. Clients may appeal the department's decision pursuant to 441—Chapter 2506 when:

1. The client's application for services as described in this chapter is denied, or
2. The services are terminated.

[**ARC 0672D**, IAB 10/14/26, effective 12/1/26]

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 173
FAMILY PLANNING SERVICES

[Prior to 7/1/83, Social Services[770] Ch 140]
[Previously appeared as Ch 140—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]
Rescinded IAB 8/1/07, effective 9/5/07

CHAPTER 174
STUDENT ABUSE REPORTS AND INVESTIGATIONS

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/1/31

441—174.1(232E) Application—not exclusive.

174.1(1) Iowa Code chapter 232E applies only to incidents of alleged student abuse that occur on or after July 1, 2025, and only if the report of the alleged student abuse is made within three years from the date of the occurrence of the incident alleged in the report.

174.1(2) Iowa Code chapter 232E does not provide an exclusive process or remedy for addressing alleged misconduct by a school employee involving a student and does not preclude or replace other available forms of reporting, investigation, or disciplinary action for complaints that do not meet the threshold of student abuse.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.2(232E) Definitions.

"Board of educational examiners" means the same as defined in Iowa Code chapter 232E.

"Credible report" means a report of alleged student abuse that is deemed by the department to be both investigable and complete and is an accepted report for the purposes of an investigation under Iowa Code chapter 232E.

"Department policies and procedures" means the written guidelines formulated by the department to be used by department personnel involved in the reporting and investigation of allegations of student abuse.

"Disposition data and information," for the purposes of disclosure of such data and information to a school employee under paragraph 174.9(2)*"b"* and as specified under subrule 174.10(3), means materially relevant data and information pertaining to the department's determination that the allegation of student abuse is substantiated.

"Identifiable," relative to an allegedly abused student or to a school employee allegedly involved in an incident, means an individual who is not anonymous and who may be identified by specific factors, such as name, age, address, or birth date.

"Identifiable source," with reference to the reporter of an allegation of student abuse, means an individual who is not anonymous; who may be identified by specific factors, such as name, age, address, or birth date; and who is available to sign the written report of alleged student abuse.

"Incident" means an occurrence of behavior that meets the definition of student abuse.

"Inconclusive," with reference to a credible report of student abuse that has been referred to law enforcement, means that, because the joint investigation has not yet been concluded, there is not sufficient evidence to determine whether the incident occurred.

"Injury" means bodily injury for which evidence of the injury is still apparent at least 24 hours after an incident.

"Investigation" means the same as defined in Iowa Code chapter 232E.

"Investigation report data and information," for the purposes of disclosure of such data and information to a school employee under paragraph 174.9(2)*"b"* and as specified under subrule 174.10(3), means materially relevant data and information pertaining to an investigation of an allegation of student abuse based upon which the department determines the alleged student abuse is substantiated.

"Investigator" means personnel of the department to whom a credible report is assigned for investigation.

"Model policy" means the policy and procedures formulated by the department of education in consultation with the department to be used in the reporting and investigating of an allegation of student abuse under Iowa Code chapter 232E.

"Nonpublic school" means the same as defined in Iowa Code chapter 232E.

"Preponderance of the evidence" means reliable, credible evidence that is of greater weight than evidence offered in opposition to it.

"Public school" means the same as defined in Iowa Code chapter 232E.

"Public school district" means the same as defined in Iowa Code chapter 232E.

"Receipt of a report" or *"receipt of a credible report"* occurs on the date of the business day on which a credible report is initially assigned to an investigator.

"School employee" means the same as defined in Iowa Code chapter 232E.

"School time" means the hours of a regular school day as specified by the board of directors of a public school district or by the authorities in charge of a nonpublic school.

"Student" means the same as defined in Iowa Code chapter 232E.

"Student abuse" means the same as defined in Iowa Code chapter 232E.

"Substantiated," with reference to a credible report of student abuse, means that, based on the investigation, there is a preponderance of the evidence indicating the incident occurred.

"Unsubstantiated," with reference to a credible report of student abuse, means that, based on the investigation, there is not a preponderance of the evidence indicating the incident occurred.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.3(232E) Abuse intake process—report of alleged student abuse.

174.3(1) If, during the abuse intake process under Iowa Code chapter 232, subchapter III, part 2, and Iowa Code chapter 235B, an identifiable source reports information that the department, in accordance with department policies and procedures, determines may constitute an allegation of student abuse, the identifiable source shall be referred to the student abuse intake process.

174.3(2) If, during the abuse intake process under Iowa Code chapter 232, subchapter III, part 2, and Iowa Code chapter 235B, the department determines the information reported by an identifiable source does not constitute an allegation of student abuse subject to investigation by the department, the department shall reject the report and may inform the identifiable source of all the following:

a. The report is rejected and the basis for the rejection.

b. Rejection of the report of alleged student abuse does not preclude other options for reporting, investigation, or disciplinary action for complaints that do not meet the threshold of student abuse, including:

(1) Contacting law enforcement.

(2) Contacting the county attorney.

(3) Contacting private counsel for the purpose of filing a civil suit or complaint.

(4) Filing a complaint with the superintendents of the public school district or the authorities in charge of the nonpublic school associated with the school employee allegedly involved in the alleged misconduct or contacting the board of educational examiners, as applicable.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.4(232E) Student abuse intake process—credible reports.

174.4(1) Following the referral of an identifiable source of a report of alleged student abuse to the student abuse intake process, the department will do all the following:

a. Assist the identifiable source in making a report of alleged student abuse. Reports shall be made in a manner similar to that specified in Iowa Code section 232.70 as adapted for application to student abuse reports in department policies and procedures.

b. Determine if the report of alleged student abuse is a credible report.

c. If the report of alleged student abuse is determined to be a credible report, refer the credible report to an investigator for investigation.

174.4(2) Credible reports. To be a credible report, a report of alleged student abuse must be deemed to be both investigable and complete by the department.

174.4(3) Investigable reports.

a. To be deemed investigable, a report of alleged student abuse must provide all the following details as specified in department policies and procedures:

(1) The person allegedly responsible for the act or omission is identifiable, was a school employee at the time of the alleged incident, and remains a school employee at the time the alleged abuse is reported.

(2) The alleged act or omission of the school employee is alleged to have occurred on school grounds during school time or on or at a school-related curricular or extracurricular activity.

(3) The alleged act or omission of the school employee resulted in injury or otherwise meets the definition of student abuse.

(4) The allegedly abused student is identifiable and is a student or was a student at the time of the alleged incident.

b. If the report of alleged student abuse is deemed not to be investigable, the report will be dismissed for lack of jurisdiction.

c. Not physical abuse.

(1) For the purposes of determining whether the alleged act or omission of a school employee constitutes physical abuse that meets the definition of student abuse under subparagraph 174.4(3)*"a"*(3), reasonable contact under circumstances described in Iowa Code section 280.21(2) does not constitute physical abuse.

(2) In determining the reasonableness of the contact or force used under subparagraph 174.4(3)*"c"*(1), the following factors will be considered:

1. The nature of the misconduct of the student, if any, precipitating the physical contact by the school employee.
2. The size and physical condition of the student.
3. The instrumentality used in making the physical contact.
4. The motivation of the school employee in initiating the physical contact.
5. The extent of injury to the student resulting from the physical contact.

174.4(4) Complete reports.

a. To be deemed complete, a report of alleged student abuse must meet all the following conditions as specified in department policies and procedures. The report must:

(1) Contain information regarding the identifiable source making the allegation of student abuse; the student allegedly abused; the school employee allegedly involved in the alleged incident; any witnesses to the alleged incident; and any person who examined, counseled, or treated the student for the alleged abuse.

(2) Include a concise statement of the facts surrounding the alleged incident, including the date, time, and place of occurrence, if known.

(3) Be reduced to writing, signed by the identifiable source, and witnessed by a person of majority age.

b. If a report of alleged student abuse is deemed incomplete by the department, the report will not be rejected unless either of the following conditions applies:

(1) The reporter of the alleged student abuse is not an identifiable source and does not sign the written report, and the report is not witnessed by a person of majority age.

(2) A reasonable person would conclude that the absence of the information missing from the report of alleged student abuse would render an investigation of the report futile or impossible.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.5(232E) Options if report dismissed or rejected during student abuse intake. If the report of alleged student abuse is dismissed as not being investigable for lack of jurisdiction or rejected as incomplete, the department may inform the identifiable source of all the following:

174.5(1) The report is being dismissed or rejected and the basis for the dismissal or rejection.

174.5(2) Dismissal or rejection of the report of alleged student abuse does not preclude other options for reporting, investigation, or disciplinary action for complaints that do not meet the threshold of student abuse, including:

a. Contacting law enforcement.

b. Contacting the county attorney.

c. Contacting private counsel for the purpose of filing a civil suit or complaint.

d. Filing a complaint with the superintendent of the public school district or the authorities in charge of the nonpublic school associated with the school employee allegedly involved in the alleged misconduct or contacting the board of educational examiners, as applicable.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.6(232E) Notification of school authorities and identifiable source regarding credible reports. The department, in accordance with department policies and procedures, will notify all the following when a report of alleged student abuse is determined to be a credible report:

174.6(1) The board of directors of the public school district or the authorities in charge of the nonpublic school associated with the school employee allegedly involved in the incident, as applicable, and the board of educational examiners, if applicable. The department of education shall cooperate with the department in completing the required notifications under this paragraph and shall provide the department with access to school contact information in a manner that ensures the accuracy of the notifications.

174.6(2) The identifiable source.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.7(232E) Investigation—duties of an investigator and school authorities.

174.7(1) *Duties of an investigator.* An investigator will do all the following:

a. Commence an investigation within 24 hours of the receipt of a credible report.

b. Based on a credible report received, if an investigator determines the alleged student abuse constitutes a criminal act:

(1) Refer the matter to law enforcement, defer the department's investigation, and work jointly with law enforcement in law enforcement's investigation. The investigator may share with law enforcement information collected by the department during the joint investigation.

(2) If the investigation is deferred under this paragraph, resume the deferred investigation following completion of the joint investigation if the investigator determines information collected during the joint investigation warrants further investigation. The investigator will complete the resumed investigation within 30 business days of its commencement and will submit a written investigation report to the entities as specified under this rule upon the completion of the resumed investigation.

c. During the investigation:

(1) Interview the allegedly abused student, any witnesses or persons who may have knowledge of the circumstances contained in the credible report, and the school employee allegedly involved in the incident identified in the credible report.

(2) Conduct the interview of the allegedly abused student and any other student in a manner similar to that specified in Iowa Code section 232.71B(7), relating to child abuse assessment interviews conducted in facilities or schools as adapted for application to student abuse interviews in department policies and procedures.

(3) Provide notification to the parent or guardian of the allegedly abused student in a manner similar to that specified in Iowa Code section 232.71B(2), relating to the notification of parents regarding a child abuse assessment as adapted for application to student abuse investigations in department policies and procedures.

(4) Provide notification to the school employee allegedly involved in the incident in a manner similar to that specified in Iowa Code section 232.71B(4), relating to the notification of a person alleged to have committed child abuse as adapted for application to student abuse investigations in department policies and procedures.

d. Complete the investigation within 30 business days of the date of receipt of the credible report unless the investigation is deferred.

e. Include in the written investigation report the information specified in department policies and procedures. At a minimum, the written investigation report will include all of the following:

(1) A general overview of the investigation.

(2) If the matter was not referred to law enforcement and the department's investigation was not deferred, a statement that, in the investigator's opinion, the allegations in the credible report are either substantiated or unsubstantiated.

(3) If the matter was referred to law enforcement, the department's investigation was deferred, and the joint investigation has not been completed, a statement that the allegations in the credible report are inconclusive pending the results of the joint investigation.

(4) Any alternative status or disposition of the investigation.

(5) Any other information relevant to the investigation and the department's determination relating to the allegation of student abuse.

174.7(2) *Duties of school authorities.*

a. Granting access and immunity.

(1) The board of directors of a public school district or the authorities in charge of a nonpublic school shall cooperate with the investigator by providing confidential access to the allegedly abused student named in the credible report for the purpose of interviewing the student and shall allow the investigator confidential access to other students for the purpose of conducting interviews to obtain relevant information.

(2) The immunity granted by Iowa Code sections 232.73 and 235B.3(11) applies to participation in good faith by boards of directors of a public school district and the authorities in charge of nonpublic schools, the facilities of a public school or nonpublic school, and public school districts in an investigation and when providing confidential access to a student.

b. The board of directors of a public school district or the authorities in charge of a nonpublic school shall provide an investigator access to an allegedly abused student's education records pursuant to 34 CFR §99.31 as amended to August 1, 2025.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.8(232E) School employee resignation during pendency of investigation. Following a determination by the department that a report of alleged student abuse is a credible report, the department will complete the investigation of the credible report in accordance with rule 441—174.7(232E), whether the school employee allegedly involved in the incident resigns any time prior to or at the time of the submission of the written investigation report.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.9(232E) Substantiated report—right of school employee to contested case proceedings and further review.

174.9(1) At the time the written investigation report is submitted to the board of directors of the public school district or the authorities in charge of the nonpublic school, as applicable, and the board of educational examiners, if applicable, under paragraph 174.7(1)*"e,"* the department will provide notice of the department's determination regarding the allegation of student abuse to the school employee who is the subject of the investigation pursuant to 441—Chapter 16.

174.9(2) If the notice of determination includes a statement that the allegation of student abuse is substantiated, the notice of determination will also inform the school employee who is the subject of the investigation of:

a. The school employee's right to contested case proceedings and further review pursuant to 441—Chapter 2506; and

b. The right and process to request additional investigation report data and information and disposition data and information as specified in department policies and procedures.

174.9(3) The appellant must appeal on or before the thirtieth day following the date of notice of the determination.

174.9(4) The department will notify the board of directors of the public school district or the authorities in charge of the nonpublic school, as applicable, and the board of educational examiners, if applicable, of the following:

a. If the school employee requests contested case proceedings under 441—Chapter 2506.

b. The proposed decision of the contested case.

c. If any party requests director's review pursuant to rule 441—subrule 2506.27(1).

d. The final decision of the contested case.

174.9(5) Any disciplinary, employment, or other action that may be taken in response to an investigation report by the directors of a public school district or the authorities in charge of a nonpublic school, and the board of educational examiners, if applicable, is stayed during the pendency of the proceedings under subrule 174.9(2).

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26; Editorial change: IAC Supplement 6/10/26]

441—174.10(232E) Case record retention—protection of identifiable source—disclosure limitations.

174.10(1) The department will retain the case record, including the intake report, the written investigation report, and all related supporting documentation, for three years from the date the written investigation report is submitted pursuant to paragraph 174.7(1)*"e"* to the director of the public school district or the authorities in charge of the nonpublic school, as applicable, and the board of educational examiners, if applicable.

174.10(2) The name and identity of the identifiable source of a report of alleged student abuse will not be disclosed with the following exceptions:

a. To department personnel and law enforcement involved in, and as necessary to perform official duties related to, the reporting and investigation of a specific allegation of student abuse.

b. To the board of educational examiners if the allegation of student abuse involves a school employee who is licensed, certified, or authorized by the board of educational examiners, or who holds an active statement of recognition issued by the board of educational examiners, as necessary to perform official duties related to the specific allegation of student abuse.

c. To other persons for good cause as determined by the department based on criteria specified in department policies and procedures.

174.10(3) Student abuse information.

a. Student abuse information is confidential and shall not be a public record under Iowa Code chapter 22. The confidentiality of all student abuse information will be maintained, except as specifically provided in these rules and department policies and procedures.

b. Student abuse information may be shared with department personnel as necessary to perform official duties.

c. With the exception of the name and identity of the identifiable source, the disclosure of which is subject to subrule 174.10(2), any investigation report data and information and disposition data and information, as specified by department policies and procedures, may be disclosed, upon request, only to the following:

(1) The student named in the report of student abuse as the victim or the student's attorney or guardian ad litem.

(2) The parent or guardian or the attorney for the parent or guardian of the student named in the report of student abuse as the victim.

(3) A person or the attorney for the person named in a report as having abused the student.

(4) Law enforcement involved in the investigation of the report of student abuse.

(5) The board of directors of the public school district or the authorities in charge of the nonpublic school, as applicable, and the board of educational examiners, if applicable, that received the written investigation report.

(6) The county attorney.

(7) The administrative law judge or court involved in a contested case proceeding or further review upon a finding that the information is necessary for the resolution of an issue arising in any phase of a case involving a determination of a substantiated allegation of student abuse.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

441—174.11(232E) Substantial compliance. Because investigative procedures seldom allow for rigid observance of the protocol, substantial compliance with these rules is required with the overriding goal of reaching a fair and unbiased resolution of a report of alleged student abuse.

[**ARC 9953C**, IAB 1/7/26, effective 3/1/26]

These rules are intended to implement Iowa Code chapter 232E.

[Filed ARC 9953C (Notice ARC 9641C, IAB 10/29/25), IAB 1/7/26, effective 3/1/26]

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CHAPTER 175
ABUSE OF CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 135]
[Previously appeared as Ch 135—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

DIVISION I
CHILD ABUSE

[Rescinded IAB 5/6/98, effective 9/1/98]

441—175.1 to **175.20** Reserved.

DIVISION II
CHILD ABUSE ASSESSMENT

Preamble

The purpose of this division is to implement requirements established in the Iowa Code which charge the department of human services with accepting reports of child abuse, assessing those reports and taking necessary steps to ensure a reported child's safety. Protection is provided through encouraging the reporting of suspected cases of abuse, conducting a thorough and prompt assessment of the reports, and providing rehabilitative services to abused children and their families. This response to reports of child abuse emphasizes child safety and engagement of a family in services, where necessary. The assessment-based approach recognizes that child protection and strong families are the responsibility not only of the family itself, but also of the larger community (including formal and informal service networks). It is the department's legal mandate to respond to reports of child abuse. The assessment approach shall allow the department to develop divergent strategies when responding to reports of child abuse, adjusting its response according to the severity of abuse, to the functioning of the family, and to the resources available within the child and family's community.

441—175.21(232,235A) Definitions.

"Adequate food, shelter, clothing, medical or mental health treatment, supervision or other care" means that food, shelter, clothing, medical or mental health treatment, supervision or other care which, if not provided, would constitute a denial of critical care.

"Allegation" means a statement setting forth a condition or circumstance yet to be proven.

"Assessment" means the process by which the department responds to all accepted reports of alleged child abuse. An "assessment" addresses child safety, family functioning, culturally competent practice, and identifies the family strengths and needs, and engages the family in services if needed. The department's assessment process occurs either through a child abuse assessment or a family assessment.

"Assessment intake" means the process by which the department receives and records a report of suspected child abuse.

"Caretaker" means a person responsible for the care of a child as defined in Iowa Code section 232.68.

"Case" means a report of suspected child abuse that has been accepted for assessment services.

"Child abuse assessment" means an assessment process by which the department responds to all accepted reports of child abuse which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(1) through (3) and (5) through (11) as amended by 2016 Iowa Acts, Senate File 2258; or which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(4) that also allege imminent danger, death, or injury to a child. A "child abuse assessment" results in a disposition and a determination of whether a case meets the definition of child abuse and a determination of whether criteria for placement on the registry are met.

"Denial of critical care" means the failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing, medical or mental health treatment, supervision or other care necessary for the child's health and welfare when financially able to do so, or when offered financial or other reasonable means to do so, and shall mean any of the following:

1. Failure to provide adequate food and nutrition to the extent that there is danger of the child suffering injury or death.
2. Failure to provide adequate shelter to the extent that there is danger of the child suffering injury or death.
3. Failure to provide adequate clothing to the extent that there is danger of the child suffering injury or death.
4. Failure to provide adequate health care to the extent that there is danger of the child suffering injury or death. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child and shall not be placed on the child abuse registry. However, a court may order that medical service be provided where the child's health requires it.
5. Failure to provide the mental health care necessary to adequately treat an observable and substantial impairment in the child's ability to function.
6. Gross failure to meet the emotional needs of the child necessary for normal development.
7. Failure to provide for the adequate supervision of the child that a reasonable and prudent person would provide under similar facts and circumstances when the failure results in direct harm or creates a risk of harm to the child.
8. Failure to respond to the infant's life-threatening conditions (also known as withholding medically indicated treatment) by providing treatment (including appropriate nutrition, hydration and medication) which in the treating physician's reasonable medical judgment will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's reasonable medical judgment any of the following circumstances apply: the infant is chronically and irreversibly comatose; the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane.

"Department" means the Iowa department of human services and includes the local offices of the department.

"Differential response" means an assessment system in which there are two discrete pathways to respond to accepted reports of child abuse, a child abuse assessment and a family assessment. The child abuse assessment pathway shall require a determination of abuse and a determination of whether criteria for placement on the central abuse registry are met.

"Facility providing care to a child" means any public or private facility, including an institution, hospital, health care facility, intermediate care facility for persons with an intellectual disability, residential care facility for persons with an intellectual disability, or skilled nursing facility, group home, mental health facility, residential treatment facility, shelter care facility, detention facility, or child care facility which includes licensed day care centers, all registered family and group day care homes and licensed family foster homes. A public or private school is not a facility providing care to a child, unless it provides overnight care. Public facilities which are operated by the department of human services are assessed by the department of inspections and appeals.

"Family assessment" means an assessment process by which the department responds to all accepted reports of child abuse which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(4), but do not allege imminent danger, death, or injury to a child. A "family assessment" does not include a determination of whether a case meets the definition of child abuse and does not include a determination of whether criteria for placement on the central abuse registry are met.

"Home" means a permanent or temporary structure where one resides, including a licensed foster family home. For the purpose of this chapter, "home" shall not be construed to include any public or

private facility, such as an institution, hospital, health care facility, intermediate care facility for persons with an intellectual disability, residential care facility for persons with an intellectual disability, skilled nursing facility, group care, mental health facility, residential treatment facility, shelter care facility, detention facility, licensed day care center, or child foster care provided by an agency.

"Illegal drug" means cocaine, heroin, amphetamine, methamphetamine or other illegal drugs, including marijuana, or combinations or derivatives of illegal drugs which were not prescribed by a health practitioner.

"Immediate threat" or *"imminent danger"* means conditions which, if no response were made, would be more likely than not to result in sexual abuse, injury or death to a child.

"Infant," as used in the definition of "denial of critical care," numbered paragraph "8," means an infant less than one year of age or an infant older than one year of age who has been hospitalized continuously since birth, who was born extremely prematurely, or who has a long-term disability.

"Nonaccidental physical injury" means an injury which was the natural and probable result of a caretaker's actions which the caretaker could have reasonably foreseen, or which a reasonable person could have foreseen in similar circumstances, or which resulted from an act administered for the specific purpose of causing an injury.

"Physical injury" means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition or damage to any bodily tissue which results in the death of the person who has sustained the damage.

"Preponderance of evidence" means evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it.

"Proper supervision" means that supervision which a reasonable and prudent person would exercise under similar facts and circumstances, but in no event shall the person place a child in a situation that may endanger the child's life or health, or cruelly or unduly confine the child. Dangerous operation of a motor vehicle is a failure to provide proper supervision when the person responsible for the care of a child is driving recklessly, or driving while intoxicated with the child in the motor vehicle. The failure to restrain a child in a motor vehicle does not, by itself, constitute a cause to assess a child abuse report.

"Rejected intake" means a report of suspected child abuse that has not been accepted for assessment.

"Reporter" means the person making a verbal or written statement to the department, alleging child abuse.

"Report of suspected child abuse" means a verbal or written statement made to the department by a person who suspects that child abuse has occurred.

"Reside" or *"resides"* means to habitually sleep or live. A person's subjective intent as to where the person resides is not relevant.

"Sex trafficking" means the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of commercial sexual activity as defined in Iowa Code section 710A.1.

"Sex trafficking victim" means a victim of sex trafficking.

"Subject of a report of child abuse" means any of the following:

1. A child named in a report as having been abused, or the child's attorney or guardian ad litem.
2. A parent or the attorney for the parent of a child named in a child abuse assessment summary as having been abused.
3. A guardian or legal custodian, or that person's attorney, of a child named in a child abuse assessment summary as having been abused.
4. A person or the attorney for the person named in a child abuse assessment summary as having abused a child.

"Unduly" shall mean improper or unjust, or excessive.

[**ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 2742C**, IAB 10/12/16, effective 12/1/16; **ARC 5248C**, IAB 11/4/20, effective 1/1/21]

441—175.22(232) Receipt of a report of suspected child abuse. Reports of suspected child abuse shall be received by local department offices, the central abuse registry, or the Child Abuse Hotline.

175.22(1) Any report made to the department which alleges child abuse, as defined in Iowa Code section 232.68, or constitutes a complaint that a child is a child in need of assistance, as defined in Iowa Code section 232.2(6), shall be accepted for assessment.

175.22(2) Reports of suspected child abuse which do not meet the legal definition of child abuse shall become rejected intakes.

a. If a report of suspected child abuse does not meet the legal definition of child abuse or is accepted as a family assessment, but a criminal act harming a child is alleged, the department shall immediately refer the matter to the appropriate law enforcement agency.

b. If a report constitutes an allegation of child sexual abuse as defined under Iowa Code section 232.68(2)*"a"*(3) as amended by 2016 Iowa Acts, Senate File 2258, except that the suspected abuse resulted from the acts or omissions of a person who was not a caretaker or was not a person who resides in a home with the child, the department shall refer the report to law enforcement orally as soon as practicable and follow up in writing within 72 hours of receiving the report.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 2742C**, IAB 10/12/16, effective 12/1/16]

441—175.23(232) Sources of report of suspected child abuse.

175.23(1) *Mandatory reporters.* Any person meeting the criteria of a mandatory reporter is required to make an oral report of the suspected child abuse to the department within 24 hours of becoming aware of the abusive incident and make a written report to the department within 48 hours following the oral report. If the person making the report has reason to believe that immediate protection for the child is advisable, that person shall also make an oral report to an appropriate law enforcement agency.

175.23(2) *Others required to report.* In addition to mandatory reporters which are so designated by the Iowa Code, there are other classifications of persons who are required, either by administrative rule or department policy, to report suspected child abuse when this is a duty identified through the person's employment. Others required to report include:

a. Income maintenance workers.

b. Certified adoption investigators.

175.23(3) *Permissive reporters.* Any person who suspects child abuse may make an oral or written report, or both, to the department. Mandatory reporters may report as permissive reporters when they suspect abuse of a child outside the scope of their professions. A permissive reporter may remain anonymous and is not required by law to report abuse.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.24(232) Assessment intake process. The primary purpose of intake is to obtain available and pertinent information regarding an allegation of child abuse and determine whether a report of suspected child abuse becomes accepted for assessment or a rejected intake.

175.24(1) To result in an assessment, the report of suspected child abuse must include some information to indicate all of the following.

a. The alleged victim of child abuse is a child.

b. The alleged perpetrator of child abuse is:

(1) A caretaker; or

(2) A person who resides in a home with the child, if the allegation is sexual abuse as defined in Iowa Code section 232.68(2)*"a"*(3) as amended by 2016 Iowa Acts, Senate File 2258; or

(3) A person who engages in or allows child sex trafficking as defined in Iowa Code section 232.68(2)*"a"*(11) as amended by 2016 Iowa Acts, Senate File 2258.

c. The alleged incident falls within the definition of child abuse.

175.24(2) If the report constitutes a child abuse allegation, a determination is made as to whether the assessment will be assigned as a child abuse assessment, to be commenced within 24 hours of receiving the report, or a family assessment, to be commenced within 72 hours of receiving the report.

a. A child abuse assessment is required for all accepted reports which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(1) through (3) and (5) through (11) as amended by 2016 Iowa Acts, Senate File 2258; or which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(4) that also

allege imminent danger, death, or injury to a child. If one or more of the following factors are met, a child abuse assessment shall be required:

(1) The alleged abuse type includes a category other than denial of critical care.

(2) The allegation requires a one-hour response or alleges imminent danger, death, or injury to a child.

(3) The child has been taken into protective custody as a result of the allegation.

(4) There is an open service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the noncustodial parent if the noncustodial parent is the alleged person responsible.

(5) The alleged person responsible is not a birth or adoptive parent, a legal guardian, or a member of the child's household.

(6) There has been a termination of parental rights in juvenile court on the alleged person responsible or on any caretaker who resides in the home.

(7) There has been prior confirmed or founded abuse within the past six months which lists any caretaker who resides in the home as the person responsible.

(8) It is alleged that illegal drugs are being manufactured or sold from the family home.

(9) The allegation is failure to thrive or that the caretaker has failed to respond to an infant's life-threatening condition.

(10) The allegation involves an incident for which the caretaker has been charged with a felony under Iowa Code chapter 726.

b. A family assessment is required for all accepted reports which allege child abuse as defined in Iowa Code section 232.68(2)*"a"*(4) but do not allege imminent danger, death, or injury to a child. If all of the following factors are met, a family assessment shall be required:

(1) The alleged abuse type is denial of critical care only.

(2) The allegation does not require a one-hour response or allege imminent danger, death, or injury to a child.

(3) The child has not been taken into protective custody as a result of the allegation.

(4) There is no current open service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the noncustodial parent if the noncustodial parent is the alleged person responsible.

(5) The alleged person responsible is a birth or adoptive parent, a legal guardian, or a member of the child's household.

(6) There has not been a termination of parental rights in juvenile court on the alleged person responsible or on any caretaker who resides in the home.

(7) There has been no prior confirmed or founded abuse within the past six months which lists any caretaker who resides in the home as the person responsible.

(8) It is not alleged that illegal drugs are being manufactured or sold from the family home.

(9) The allegation is not failure to thrive or that the caretaker has failed to respond to an infant's life-threatening condition.

(10) The allegation does not involve an incident for which the caretaker has been charged with a felony under Iowa Code chapter 726.

175.24(3) Only the person making a report of suspected abuse may be contacted during the intake process to expand upon or to clarify information in the report. Any contact with subjects of the report or with anyone outside the department of human services, other than the original reporter(s), automatically causes the report of suspected child abuse to be accepted for assessment.

175.24(4) If the report of suspected child abuse fails to constitute a child abuse allegation.

a. When it is determined that the report of suspected child abuse fails to constitute a child abuse allegation, the report of suspected child abuse shall become a rejected intake and shall be evaluated to determine whether the information reported constitutes a complaint that a child is a child in need of assistance.

b. When it is determined that a report of a child needing the assistance of the court fails to meet the definition of a child in need of assistance, the report shall become a rejected intake.

c. Rejected intake information shall be maintained by the department for three years from the date the report was rejected and shall then be destroyed.

175.24(5) Intake information shall be provided as follows:

a. The county attorney shall be notified of all reports of suspected child abuse.

b. When a report of suspected child abuse is received which does not meet the requirements for an assessment or is accepted as a family assessment and there is information about a criminal act harming a child, the department shall notify law enforcement of the report.

c. If the department has reasonable cause to believe that a child or youth for whom the department has responsibility for placement, care, or supervision is or is at risk of being a victim of sex trafficking or a severe form of trafficking in persons, the department must identify that child or youth as such, document it in agency records, and refer the information as necessary to determine appropriate services, in accordance with 42 U.S.C. Section 671(a)(9)(C). Additionally, the department shall report the child or youth immediately, and in no case later than 24 hours, to law enforcement authorities, in accordance with 42 U.S.C. Section 671(a)(34).

[**ARC 8453B**, IAB 1/13/10, effective 3/1/10; **ARC 1156C**, IAB 10/30/13, effective 1/1/14; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 2742C**, IAB 10/12/16, effective 12/1/16]

441—175.25(232) Assessment process. A child abuse assessment shall be initiated within 24 hours following the report of suspected child abuse. A family assessment shall be initiated within 72 hours following the report of suspected child abuse. The primary purpose in conducting an assessment is to protect the safety of the child named in the report. The secondary purpose of the assessment is to engage the child's family in services in a culturally competent way, to enhance family strengths and to address needs, where this is necessary and desired.

175.25(1) *Observing and evaluating the child's safety.* A safety assessment and risk assessment will be completed during the course of a child abuse assessment or family assessment.

a. During a child abuse assessment, when there is an immediate threat to the child's safety, reasonable efforts shall be made to observe the alleged child victim and evaluate the safety of the child named in the report within one hour of receipt of the report of suspected child abuse. Otherwise, reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 24 hours of receipt of the report of suspected child abuse.

(1) When the alleged perpetrator clearly does not have access to the alleged child victim, reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 96 hours of receipt of the report of suspected child abuse.

(2) When reasonable efforts have been made to observe the alleged child victim within the specified time frames and the worker has established that there is no risk to the alleged child victim, the observation of the alleged child victim may be delayed or waived with supervisory approval.

b. During a family assessment, reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 72 hours of receipt of the report of suspected child abuse.

(1) When reasonable efforts have been made to observe the alleged child victim within the specified time frame and the worker has established that there is no risk to the alleged child victim, the observation of the alleged child victim may be delayed or waived with supervisory approval.

(2) If at any time during a family assessment a child is determined unsafe or in imminent danger, it appears that the immediate safety or well-being of a child is endangered, it appears that the family may flee or the child may disappear, or that the facts otherwise warrant, the department shall immediately commence a child abuse assessment as defined in Iowa Code section 232.71B as amended by 2013 Iowa Acts, House File 590.

(3) If the department determines that safety issues continue to require a child to reside outside of the child's home at the conclusion of a family assessment, the department shall transfer the assessment to the child abuse assessment pathway for a disposition.

c. If the department has reasonable cause to believe that a child or youth for whom the department has responsibility for placement, care, or supervision is or is at risk of being a victim of sex trafficking or a severe form of trafficking in persons, the department must identify that child or youth as such, document it in agency records, and determine appropriate services, in accordance with 42 U.S.C. Section 671(a)(9)(C).

Additionally, the department shall report the child or youth immediately, and in no case later than 24 hours, to law enforcement authorities, in accordance with 42 U.S.C. Section 671(a)(34).

175.25(2) *Interviewing the alleged child victim.* The primary purpose of an interview with the child, during the course of a child abuse assessment or family assessment, is to gather information regarding the abuse allegation, the child's immediate safety, and risk of abuse. During a child abuse assessment, the child protection worker shall also identify the person or persons responsible for the alleged abuse as well as the nature, extent, and cause of injuries, if any, to the child named in the report of suspected child abuse.

175.25(3) *Interviewing subjects of the report and other sources.*

a. During a child abuse assessment, attempts shall be made to conduct interviews with subjects of the report and persons who have relevant information to share regarding the allegations. This may include contact with physicians to assess the child's condition. The child's custodial parents or guardians and the alleged perpetrator (if different) shall be interviewed or offered the opportunity to be interviewed. The court may waive the requirement of the interview for good cause.

b. During a family assessment, the child's custodial parents or guardians shall be interviewed or offered the opportunity to be interviewed. The child protection worker may request information from any person believed to have knowledge regarding a child named in an assessment. A family assessment requires the cooperation of the family; should a family choose not to participate, the department is required to transfer the assessment to the child abuse assessment pathway for a disposition.

175.25(4) *Gathering of physical and documentary evidence.* During a child abuse assessment, evidence shall be gathered from, but not be limited to, interviews, observations, photographs, medical and psychological reports and records, reports from child protection centers, written reports, audiotapes and their transcripts or summaries, videotapes and their transcripts or summaries, or other electronic forms.

175.25(5) *Evaluating the home environment and relationships of household members.* An evaluation of the home environment shall be conducted during the course of an assessment with the consent of the parent or guardian. If permission is refused, the juvenile court may authorize the worker to enter the home to observe or interview the child.

a. If protective concerns are identified, the child protection worker shall evaluate the child named in the report and any other children in the same home as the parents or other persons responsible for their care.

(1) Each assessment shall include a full description of observations and information gathered during the assessment process. This description shall provide information which evaluates the safety of the child named in the report.

(2) If the child protection worker has concerns about a child's safety or a family's functioning, the worker shall conduct a more intensive assessment until those concerns are addressed.

b. When an assessment is conducted at an out-of-home setting, an evaluation of the environment and relationships where the abuse allegedly occurred shall be conducted.

c. The child abuse assessment shall include a description of the name, age, and condition of other children in the same home as the child named in the report.

175.25(6) *Evaluating the information.* During a child abuse assessment, evaluation of information shall include an analysis, which considers the credibility of the physical evidence, observations, and interviews, and shall result in a conclusion of whether or not to confirm the report of suspected child abuse.

175.25(7) *Determining placement on central abuse registry.* During a child abuse assessment, a determination of whether the report data and disposition data of a confirmed case of child abuse is subject to placement on the central abuse registry pursuant to Iowa Code section 232.71D shall be made on each assessment. Determining placement on the central abuse registry is not applicable in a family assessment.

175.25(8) *Service recommendations and referrals.* During or at the conclusion of a child abuse assessment or a family assessment, the department shall consult with the child's family to offer services to the child and the child's family which address strengths and needs identified in the assessment. The department may recommend information, information and referral, community care referral, or services provided by the department. If it is believed that services are necessary for the protection of the abused child or other children in the home, juvenile court intervention shall be sought.

a. Information or information and referral.

(1) Either information or information and referral shall be offered when:

1. A family assessment has identified the child to be at low risk of future abuse or neglect; or

2. A child abuse assessment has identified the abuse is not confirmed and the child is believed to be at low risk of future abuse or neglect; or

3. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at low risk of future abuse or neglect.

(2) Recommendation options for information and information and referral.

1. When no service needs are identified, the worker may recommend no service; or

2. When service needs are identified, the worker may recommend new or continuing services to the family to be provided through informal supports; or

3. When service needs are identified, the worker may recommend new or continuing services to the family to be provided through community organizations.

b. Referral to community care.

(1) A referral to community care shall be offered when:

1. A family assessment has identified the child to be at moderate or high risk of future abuse or neglect; or

2. A child abuse assessment has identified the abuse is not confirmed and the child is believed to be at moderate or high risk of future abuse or neglect; or

3. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at moderate risk of future abuse or neglect.

(2) Referral to community care not offered. A referral to community care shall not be offered when any child in the family has an open child welfare service case with the department, a child in need of assistance petition was filed or is pending, or if the abuse occurred in an out-of-home setting.

(3) Responsibilities for community care referral.

1. At the conclusion of a family assessment, the department shall transfer the case, if appropriate, to a contracted provider to review the service plan for the child and family.

2. The contracted provider shall make a referral to the department abuse hotline if a family's noncompliance with a service plan places a child at risk.

- If any of the criteria for child abuse as defined in Iowa Code section 232.68 are met, the department shall commence a child abuse assessment.
- If criteria for a child in need of assistance as defined in Iowa Code section 232.2(6) are met, the department shall determine whether to request a child in need of assistance petition.

c. Referral for department services.

(1) The department shall provide or arrange for and monitor services for abused children and their families on a voluntary basis or under a final or intermediate order of the juvenile court when:

1. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at high risk of future abuse or neglect; or

2. A child abuse assessment has identified the abuse is founded.

(2) The worker shall recommend new or continuing services to the family to be provided by the department, either directly or through contracted agencies.

(3) Families that refuse voluntary services shall be referred for a child in need of assistance petition through juvenile court.

175.25(9) *Court action following assessment.* If, upon completion of an assessment performed under Iowa Code section 232.71B as amended by 2013 Iowa Acts, House File 590, the department determines that the best interests of the child require juvenile court action, the department shall act appropriately to initiate the action.

a. If at any time during the assessment process the department believes court action is necessary to safeguard a child, the department shall act appropriately to initiate the action.

b. The department shall assist the juvenile court or district court during all stages of court proceedings involving an alleged child abuse case in accordance with Iowa Code section 232.71C as amended by 2013 Iowa Acts, House File 590.

[**ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14; **ARC 2069C**, IAB 8/5/15, effective 10/1/15]

441—175.26(232) Completion of a written assessment report. The child protection worker shall complete a written assessment report as follows:

175.26(1) *Completion of a child abuse assessment report.* A child abuse assessment report shall be completed within 20 business days of the receipt of the child abuse report. In most instances, a child abuse assessment report shall be developed in conjunction with the child and family being assessed. A child abuse assessment report shall consist of two parts as follows:

a. Report and disposition data. A child abuse assessment report shall include report and disposition data as follows:

(1) Allegations: the report of suspected child abuse which caused the assessment to be initiated and additional allegations raised after the report of suspected child abuse becomes a case that have not been previously investigated or assessed. If the report of suspected child abuse was initially accepted as a family assessment, the reason why it was transferred to a child abuse assessment shall be identified.

(2) Evaluation of the child's safety: evaluation of the child's safety and the risk for occurrence or reoccurrence of abuse. Criteria to be used in the evaluation of the child's safety include, but are not limited to, the severity of the incident or condition, chronicity of the incident or condition, age of the child, attitude of the person alleged responsible, current services or supports, access of the person alleged responsible for the abuse to the child, and protectiveness of the parent or caretaker who is not alleged responsible for the abuse.

(3) Findings and contacts: a description of the child's condition including identification of the nature, extent, and cause of the injuries, if any, to the child named in the report; identification of the injury or risk to which the child was exposed; the circumstances which led to the injury or risk to the child; the identity of the person alleged to be responsible for the injury or risk to the child; an evaluation of the home environment; the name and condition of other children in the same home as the child named in the report if protective concerns are identified; a list of collateral contacts; and a history of confirmed or founded abuse.

(4) Determination regarding the allegations of child abuse: a statement of determination of whether the allegation of child abuse was founded, confirmed but not placed on the central abuse registry, or not confirmed. The statement shall include a rationale for placing or not placing the report on the central abuse registry.

(5) Recommendation for services as specified in 175.25(8) and a statement describing whether services are necessary to ensure the safety of the child or to prevent or remedy other identified problems.

1. The statement shall include the type of services recommended, if any, and whether these services are to be provided by the department, a child welfare service contractor, another community organization, other informal supports, or another source.

2. If services are already being provided, the statement shall include a recommendation whether these services should continue.

(6) Juvenile court recommendation: a statement describing whether juvenile court action is necessary to ensure the safety of the child; the type of action needed, if any; and the rationale for the recommendation.

(7) Criminal court recommendation: a statement describing whether criminal court action is necessary and the rationale for the recommendation.

(8) Addendum: An addendum to a child abuse assessment report shall be completed within 20 business days when any of the following occur:

1. New information becomes available that would alter the finding, conclusion, or recommendation of the report.

2. Substantive information that supports the finding becomes available.

3. A subject who was not previously interviewed requests an interview to address the allegations of the report.

4. A review or a final appeal decision modifies the report.

b. Use of assessment data. A safety assessment, family risk assessment, and safety plan, if applicable, may be used as part of the child's initial case plan, referenced at 441—subrule 130.7(3), for cases in which the department will provide services.

175.26(2) *Completion of a family assessment report.* A family assessment report shall be completed within ten business days of the receipt of the report of suspected child abuse. A family assessment report shall consist of assessment data only.

a. Assessment data. A family assessment report shall include information pertaining to the department's evaluation of a family, which includes:

(1) Allegations: the report of suspected child abuse which caused the assessment to be initiated and additional allegations raised after the report of suspected child abuse becomes a case that have not been previously assessed.

(2) Evaluation of the child's safety: evaluation of the child's safety and the risk for occurrence or reoccurrence of abuse. Criteria to be used in the evaluation of the child's safety include, but are not limited to, the severity of the incident or condition, chronicity of the incident or condition, age of the child, attitude of the person alleged responsible, current services or supports, access of the person alleged responsible for the abuse to the child, and protectiveness of the parent or caretaker who is not alleged responsible for the abuse.

(3) Contacts: description of the circumstances that led to the allegations of abuse; strengths and needs of the child, and of the child's parent, home, and family; any information obtained from others during the assessment; a history of confirmed or founded abuse; and an evaluation of the home environment and evaluation of any other children in the same home as the parents or other persons responsible for the children's care.

(4) Recommendation for services as specified in 175.25(8) and a statement describing whether services are necessary to ensure the safety of the child or to prevent or remedy other identified problems.

1. The statement shall include the type of services recommended, if any, and whether these services are to be provided by the department, a child welfare service contractor, another community organization, other informal supports, or another source.

2. If services are already being provided, the statement shall include a recommendation whether these services should continue.

b. Use of assessment data. A safety assessment, family risk assessment, and safety plan may be used as part of the information referred for any services in which the family voluntarily agrees to participate.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.27(232) Contact with juvenile court or the county attorney. The child protection worker may orally contact juvenile court or the county attorney, or both, as circumstances warrant.

175.27(1) *Report of intake.* When a report of suspected child abuse is accepted or rejected for assessment, the county attorney shall be provided a child protective service intake form, with information about the allegation of child abuse and with identifying information about the subjects of the report.

175.27(2) *Report of disposition.* The child protection worker shall provide the juvenile court and the county attorney with a copy of the child abuse assessment report, which pertains to the findings, determinations, and recommendations regarding the child abuse assessment.

175.27(3) *Report of assessment.* The child protection worker shall provide the county attorney and the juvenile court with a copy of the family risk assessment, safety assessment, safety plan, and family assessment report when any of the following occur:

a. County attorney's or juvenile court's assistance necessary. The worker requires the court's or the county attorney's assistance to complete the assessment process.

b. Court's protection needed. The worker believes that the child requires the court's protection.

c. Child adjudicated. The child is currently adjudicated or pending adjudication under a child in need of assistance petition or a delinquency petition.

d. County attorney or juvenile court requests copy. The county attorney or juvenile court requests a copy of the child abuse assessment data. The child protection worker shall document when the assessment data is provided to the county attorney or juvenile court and the rationale provided for the request.

[**ARC 8453B**, IAB 1/13/10, effective 3/1/10; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.28(232) Consultation with health practitioners or mental health professionals. The child protection worker may contact a health practitioner or a mental health professional as circumstances

warrant and shall contact a health practitioner or a mental health professional when the worker requires the assistance of the health practitioner or mental health professional in order to complete the assessment process or when the worker requires the opinion or advice of the health practitioner or mental health professional in order to determine if the child requires or should have required medical, health or mental health care as a result of suspected abuse.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.29(232) Consultation with law enforcement.

175.29(1) During the course of a child abuse assessment, the child protection worker may contact law enforcement as warranted and shall contact law enforcement when the worker believes that:

a. The abuse reported may require a criminal investigation and subsequent prosecution.

b. The child must be separated from the person responsible for the abuse.

c. Contact by the child protection worker with the family will result in a volatile and dangerous response by the child or family members.

175.29(2) During the course of a family assessment, the child protection worker shall not involve law enforcement for the purposes of a joint investigation, but shall immediately refer any information regarding a criminal act harming a child to the appropriate law enforcement agency.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.30(232) Information shared with law enforcement. When the department is jointly conducting a child abuse assessment with law enforcement personnel, the department may share information gathered during the child abuse assessment process when an assessment is conducted in conjunction with a criminal investigation. When the department has rejected an intake or an intake is accepted for a family assessment, only the information collected at intake (excluding reporter information) may be shared with law enforcement.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.31(232) Completion of required correspondence.

175.31(1) *Notification to parents that an assessment is being conducted.* Written notice shall be provided to the parents of a child who is the subject of an assessment within five working days of commencing an assessment. Both custodial and noncustodial parents shall be notified, if their whereabouts are known. If it is believed that notification will result in danger to the child or others, an emergency order to prohibit parental notification shall be sought from juvenile court.

175.31(2) *Notification of completion of assessment and right to request correction.* Written notice which indicates that the child abuse assessment is completed shall be provided to all subjects of a child abuse assessment and to the mandatory reporter who made the report of child abuse. Both custodial and noncustodial parents shall be notified if their whereabouts are known.

a. The notice shall contain the following information pursuant to Iowa Code section 235A.19:

(1) A subject may request correction of the information contained within the child abuse assessment report if the subject disagrees with the information.

(2) A person named responsible for the abuse has the right to appeal if the department does not correct the data or findings as requested.

(3) A subject, other than the person named responsible for the abuse, has the opportunity to file a motion to intervene in an appeal hearing.

b. If the child abuse assessment results in a determination that abuse is confirmed, the notice shall indicate the type of abuse, name of the child and name of the person responsible for the abuse and whether the report has been placed on the central abuse registry.

c. The department shall provide written notice to the parent or guardian of each child listed in the family assessment report of the completion of the assessment and review any service recommendations. Because no determination concerning child abuse or neglect is made and nothing is reported to the central abuse registry, a subject of a family assessment shall not be afforded the opportunity for a contested case hearing pursuant to Iowa Code chapter 17A.

[**ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.32(232,235A) Case records. The assessment case record shall contain the assessment report as described in rule 441—175.26(232) and any related correspondence or information which pertains to the assessment or to the child and family. The name of the person who made the report of child abuse shall not be disclosed.

175.32(1) *Child abuse assessment report.* A child abuse assessment report has two parts.

a. Report and disposition data as described in 175.26(1)*"a."* Subjects of the report have access to report and disposition data, including, where applicable, confirmation of placement on the central abuse registry for abuse reports meeting the criteria pursuant to Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File 590. A child abuse assessment report shall be submitted to the central abuse registry only if the abuse is confirmed and determined to meet the criteria pursuant to Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File 590.

b. Assessment data as described in 175.26(1)*"b"* shall be available to subjects. Release of assessment data shall be accomplished only when the parent or guardian approves the release as provided in Iowa Code section 217.30 or as specified in Iowa Code section 235A.15. Assessment data shall not be submitted to the central abuse registry.

175.32(2) *Family assessment report.* A family assessment report includes assessment data only as described in 175.26(2)*"b."* Assessment data shall be available to subjects. Release of assessment data shall be accomplished only when the parent or guardian of a child named in a family assessment report approves the release as provided in Iowa Code section 217.30 or as specified in Iowa Code section 235A.15. Assessment data shall not be submitted to the central abuse registry.

175.32(3) *Child abuse assessments where abuse was confirmed but not placed on the central abuse registry.* The following conditions apply to case records for assessments in which abuse was confirmed but not placed on the central registry.

a. Access to the report data and disposition data is authorized only to the subjects of the report, the child protection worker, the law enforcement officer responsible for assisting in the assessment or for the temporary emergency removal of a child from the child's home, the multidisciplinary team assisting the department in the assessment of the abuse, the county attorney, juvenile court, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department or contract personnel necessary for official duties, the department of justice, and the attorney for the department.

b. The child abuse assessment is retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The child abuse assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 9. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

175.32(4) *Child abuse assessments not placed on the central abuse registry where abuse was not confirmed.* The following conditions apply to case records for assessments in which abuse was not confirmed and not placed on the central registry:

a. Access to the assessment data on a child abuse assessment summary where abuse was not determined to have occurred and, therefore, the assessment was not placed on the central abuse registry is authorized only to the subjects of the assessment, the child protection worker, the county attorney, juvenile court, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department of justice, and department or contract personnel necessary for official duties.

b. Records are retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The child abuse assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 2505. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

175.32(5) *Family assessment.* The following conditions apply to case records for all family assessments:

a. Access to the assessment data on a family assessment report is authorized only to the subjects of the assessment, the child protection worker, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department of justice, and department or contract personnel necessary for official duties.

b. Records are retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The family assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 2505. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

[**ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 1156C**, IAB 10/30/13, effective 1/1/14; Editorial change: IAC Supplement 6/10/26]

441—175.33(232,235A) Child protection centers. The department may contract with designated child protection centers for assistance in conducting child abuse assessments. When a child who is the subject of an assessment is interviewed by staff at a child protection center, that interview may be used in conjunction with an interview conducted by the child protection worker. Written reports developed by the child protection center shall be provided to the child protection worker and may be included in the assessment case record. Video or audio records are considered to be part of the assessment process and shall be maintained by the child protection center under the same confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 2505. Services or assistance from a child protection center will not be available through a family assessment. Law enforcement may refer families as appropriate.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14; Editorial change: IAC Supplement 6/10/26]

441—175.34(232) Department-operated facilities. When an allegation of child abuse occurs at a department-operated facility, the allegation shall be referred to the department of inspections and appeals for investigation or assessment.

441—175.35(232,235A) Jurisdiction of assessments. Child protection workers serving the county in which the child's home is located have primary responsibility for completing the assessment except when the suspected abuse occurs in an out-of-home placement. Circumstances in which the department shall conduct an assessment when another state is involved include the following:

175.35(1) *Child resides in Iowa but incident occurred in another state.* When the child who is the subject of a report of suspected abuse physically resides in Iowa but has allegedly been abused in another state, the worker shall do all of the following:

a. Obtain available information from the reporter.

b. Make an oral report to the office of the other state's protective services agency and request assistance from the other state in completing the assessment.

c. Complete the assessment with assistance, as available, of the other state.

175.35(2) *Child resides in another state, but is present within Iowa.* When the child who is the subject of a report of abuse is a legal resident of another state, but is present within Iowa, the worker receiving the report shall do all of the following:

a. Act to ensure the safety of the child.

b. Contact the child's state of legal residency to coordinate the assessment of the report.

c. Commence an assessment if the state of legal residency declines to conduct an investigation.

175.35(3) *Child resides in another state and perpetrator resides in Iowa.* When the child who is the subject of a report of abuse resides in another state and the perpetrator resides in Iowa, the worker receiving the report shall do all of the following:

a. Contact the state where the child resides and offer assistance to that state in its completion of a child abuse assessment. This assistance shall include an offer to interview the person allegedly responsible for the abuse and any other relevant source of information.

b. Commence an assessment if the child's state of legal residency declines to conduct an investigation.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.36(235A) Multidisciplinary teams. Multidisciplinary teams shall be developed in county or multicounty areas in which more than 50 child abuse cases are received annually. These teams may be used as an advisory group to assist the department in conducting child abuse assessments. Multidisciplinary teams consist of professionals practicing in the disciplines of medicine, public health, mental health, social work, child development, education, law, juvenile probation, law enforcement, nursing, and substance abuse counseling. Members of multidisciplinary teams shall maintain confidentiality of cases in which they provide consultation. Rejected intakes shall not be shared with multidisciplinary teams since the rejected intakes are not considered to be child abuse information. During the course of a child abuse assessment, information regarding the initial report of child abuse and information related to the child and family functioning may be shared with the multidisciplinary team. After a conclusion is made, only report data and disposition data on confirmed cases of child abuse may be shared with the team members. When the multidisciplinary team is created, all team members shall execute an agreement, filed with the central abuse registry, which specifies:

175.36(1) *Consultation.* The team shall be consulted solely for the purpose of assisting the department in the child abuse assessment and diagnosis of child abuse cases.

175.36(2) *Redissemination.* No team member shall redisseminate child abuse information obtained through the multidisciplinary team. This shall not preclude redissemination of information as authorized by Iowa Code section 235A.17 when an individual team member has received information as a result of another authorized access provision of the Iowa Code.

175.36(3) *Department not bound.* The department shall consider the recommendation of the team in a specific child abuse case but shall not, in any way, be bound by the recommendation.

175.36(4) *Confidentiality provisions.* Any written report or document produced by the team pertaining to an assessment case shall be made a part of the file for the case and shall be subject to all confidentiality provisions of 441—Chapter 2505, unless the child abuse assessment results in placement on the central abuse registry in which case the written report or document shall be subject to all confidentiality provisions of Iowa Code chapter 235A.

175.36(5) *Written records.* Any written records maintained by the team which identify an individual child abuse assessment case shall be destroyed when the agreement lapses.

175.36(6) *Compensation.* Consultation team members shall serve without compensation.

175.36(7) *Withdrawal from contract.* Any party to the agreement may withdraw with or without cause upon the giving of 30 days' notice.

175.36(8) *Expiration date.* The date on which the agreement will expire shall be included.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14; Editorial change: IAC Supplement 6/10/26]

441—175.37(232) Community education. The department shall conduct a continuing publicity and educational program for the personnel of the department, mandatory reporters, and the general public to encourage recognition and reporting of child abuse, to improve the quality of reports of child abuse made to the department, and to inform the community about the assessment-based approach to child abuse cases.

441—175.38(235) Written authorizations. Requests for information from members of the general public as to whether a person is named on the central abuse registry as having abused a child shall be submitted on the authorization for release of child abuse information form to the county office of the department or the central abuse registry. The form shall be completed and signed by the person requesting the information and the person authorizing the check for the release of child abuse information.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.39(232) Founded child abuse. Reports of child abuse where abuse has been confirmed shall be placed on the central abuse registry as founded child abuse for either five or ten years under any of the circumstances specified by Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File

590. When none of the placement criteria listed in Iowa Code section 232.71D(3)*"b"* as amended by 2013 Iowa Acts, House File 590, are applicable, reports of denial of critical care by failure to provide adequate clothing or failure to provide adequate supervision and physical abuse where abuse has been confirmed and determined to be minor, isolated, and unlikely to reoccur shall not be placed on the central abuse registry as a case of founded child abuse. The confirmed abuse shall be placed on the registry unless all three conditions are met.

175.39(1) *Confidentiality of founded child abuse report and data.* The confidentiality of report and disposition data pertaining to founded child abuse shall be maintained as provided in Iowa Code chapter 235A. Access to the report and disposition data on founded child abuse is authorized only as provided in Iowa Code section 235A.15.

175.39(2) *Sealing and expungement of founded child abuse report and data.* Report and disposition data pertaining to founded child abuse shall be sealed and expunged as provided in Iowa Code section 235A.18.

[**ARC 9698B**, IAB 9/7/11, effective 8/15/11; **ARC 0487C**, IAB 12/12/12, effective 2/1/13; **ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.40(235A) Retroactive reviews. Rescinded IAB 9/7/11, effective 8/15/11.

441—175.41(235A) Access to child abuse information. Requests for child abuse information shall include sufficient information to demonstrate that the requesting party has authorized access to the information.

175.41(1) *Written requests.* Requests for child abuse information shall be submitted on a Request for Child Abuse Information form to the county office of the department, except requests made for the purpose of determining employability of a person in a department-operated facility shall be submitted to the central abuse registry. Subjects of a report may submit a request for child abuse information to the county office of the department on a request for child abuse information form, a notice of child abuse assessment: founded form, a notice of child abuse assessment: confirmed not registered form, a notice of child abuse assessment: not confirmed form, or a family assessment report form. The county office is granted permission to release child abuse information to the subject of a report immediately upon verification of the identity and subject status.

175.41(2) *Oral requests.* Oral requests for child abuse information may be made when a person making the request believes that the information is needed immediately and if the person is authorized to access the information. When an oral request to obtain child abuse information is granted, the person approving the request shall document the approval to the central abuse registry through use of a request for child abuse information form or a notice of child abuse assessment: founded form.

Upon approval of any request for child abuse information authorized by this rule, the department shall withhold the name of the person who made the report of child abuse unless ordered by a juvenile court or district court after a finding that the person's name is needed to resolve an issue in any phase of a case involving child abuse. Written requests and oral requests do not apply to child abuse information that is disseminated to an employee of the department, to a juvenile court, or to the attorney representing the department as authorized by Iowa Code section 235A.15.

175.41(3) *Written authorizations.* Requests for information from members of the general public as to whether a person is named on the central abuse registry as having abused a child shall be submitted on an Authorization for release of child abuse information form to the county office of the department or the central abuse registry. The form shall be completed and signed by the person requesting the information and the person authorizing the check for the release of child abuse information. The department shall not provide requested information when the authorization form is incomplete. Incomplete authorization forms shall be returned to the requester.

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

441—175.42(235A) Person conducting research. The supervisor of the central abuse registry shall be responsible for determining whether a person requesting child abuse information is conducting bona fide research, whether the research will further the official duties and functions of the central abuse registry,

and whether identified information is essential to the research design. A bona fide research design is one which shows evidence of a good-faith, academically objective and sincere intent to add to the body of knowledge about child abuse. To make this determination, the central abuse registry shall require the person to submit credentials and the research design. Additional criteria for approval of a research project may include whether the research involves contact with subjects of child abuse information, and whether contact with department personnel is required to complete the research design. If it is determined that the research will involve use of identified information, the central abuse registry shall also determine under what circumstances and in what format the information is to be used and shall execute an agreement with the researcher which will enable the researcher to obtain access to identified information on subjects of child abuse investigations, as an agent of the central abuse registry. The department will require the researcher to assume costs incurred by the department in obtaining or providing information for research purposes. The department shall keep a public record of persons conducting this research.

175.42(1) *Child abuse factors.* For purposes of conducting research pursuant to Iowa Code sections 235A.15 and 235A.23, official duties and functions of the central abuse registry shall include analysis or identification of child abuse factors in at least one of the following areas:

a. Causes of abuse—victim, parent and perpetrator characteristics, types of abuse, and correlations to family and environmental factors.

b. Effects of abuse—immediate and long-term effects of abuse on the individual child victim, the child's family and the perpetrator, in areas such as family functioning, foster placement, emotional and medical problems, and criminal activity; and effects of abuse on the community and society in general.

c. Prevention of abuse—intervention, prevention and treatment strategies.

d. Treatment of abuse—impact of service delivery upon recidivism and maintenance of the family unit.

e. Reporting of abuse—mandatory and permissive reporter characteristics, training needs, and perception of the department's protective services to children and families.

f. Identification of strengths and weaknesses in statute, policy or practice concerning child abuse services.

175.42(2) *Guidelines.* To be accepted by the central abuse registry, a research proposal originating outside the department shall meet the following guidelines:

a. The proposal shall meet the criteria listed above as "official duties and functions" of the central abuse registry.

b. The research shall be conducted by a competent researcher, evidenced by affiliation with a recognized human services agency, government body, or academic, social work or medical facility. The researcher shall demonstrate an ability to conduct nonbiased research and present findings in a professional and responsible manner which will benefit the department in providing protective services to children and families.

c. The proposed research shall not unduly interfere with the ongoing duties and responsibilities of department staff.

d. When the proposed research includes contact with subjects of child abuse information, the research design shall reflect a plan for initial subject contact by the department, which includes the following:

(1) Subjects shall be informed in writing of their right to refuse to participate in the research.

(2) Subjects shall receive written assurance that their participation in the research will not affect eligibility for services.

(3) Department staff shall be advised of research goals and procedures prior to contact with subjects, in order to answer questions which may arise.

(4) Subjects shall receive written assurance that when identifying information is released by the central abuse registry to research staff, the information will remain confidential and that all child abuse information will be deidentified prior to publication of the research findings.

175.42(3) *Approval procedures.* Procedures for approval of a research proposal are conducted as follows:

a. The supervisor of the central abuse registry shall designate a person to be the single point of contact (SPOC) for all research proposals requesting child abuse information or involving department staff who provide child protective services. All proposals shall be routed to the SPOC at the Division of Adult, Children and Family Services, Department of Human Services, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Having received a research proposal, the SPOC shall log the date the proposal was received and other identifying information about the researcher and the research design and shall convene a research advisory committee to review the proposal. This committee may consist of:

(1) The unit supervisor of the child and dependent adult abuse registry, when applicable.

(2) The unit managers for the programs addressed by the research proposal.

(3) The research specialist.

(4) Representatives from the field, including a service area manager or designee and one representative from a service area, appointed by the service area manager, if a specific service area is involved.

(5) A representative from the department's division of data management, when the proposal involves use of one of the department's computerized data systems.

(6) A representative of the attorney general's office, when the proposal involves legal questions or issues.

(7) Other persons whom the SPOC may designate to assist in the review.

c. The SPOC is responsible for ensuring that advisory committee members receive copies of the research proposal.

d. The advisory committee may meet in person or by teleconference.

e. The researcher may, at the discretion of the SPOC, be provided an opportunity to address the advisory committee concerning the research proposal and answer questions about the research design.

f. The committee shall determine the value of the proposed research and formulate recommendations for acceptance of the proposal (with conditions as necessary) or rejection of the proposal (with rationale for the rejection). These recommendations shall be submitted to the SPOC.

g. The SPOC shall transmit the committee's recommendations, with additional comments and recommendations, as needed, to the division administrators for the divisions involved.

h. The division administrators shall review committee recommendations and submit the research proposal to the director or designee for final approval.

i. After review by the director, the proposal shall be returned to the SPOC, who shall notify the researcher of the director's decision, which decision shall be final.

j. If the research proposal is approved, the SPOC shall prepare a written research agreement with the researcher which provides:

(1) The purpose of the research.

(2) The research design or methodology.

(3) The control of research findings and publication rights of all parties, including the deidentification of child abuse information prior to publication.

(4) The duties of all parties in conducting the research.

(5) The transfer of funds, if applicable.

k. The SPOC shall be responsible for securing written approval of the research agreement from the attorney general's office, applicable division administrators, and the researcher.

l. The SPOC shall be responsible for maintaining the research agreement throughout the research project and renewing or modifying the agreement when necessary.

441—175.43(235A) Child protection services citizen review panels. The purposes of the child protection services citizen review panels established in this rule are to comply with requirements set forth by the Child Abuse Prevention and Treatment Act and to take advantage of this process to identify strengths and weaknesses of the child protective service system as a whole, including community-based services and agencies. The specific objectives are to clarify expectations for child protective services with current policy; to review consistency of practice with current policy; to analyze trends and recommend policy to

address them; and to provide feedback on what is or is not working, and why, and to suggest corrective action if needed.

175.43(1) *Establishment of panels.* The department shall establish at least three panels, with at least one panel each at the state level, multicounty level, and county level. The department may designate as panels one or more existing entities established under state or federal law, such as multidisciplinary teams, if the entities have the capacity to satisfy the requirements of the function of a citizen review panel set forth in the Child Abuse Prevention and Treatment Act and the department ensures that the entities will satisfy the requirements. The department shall establish procedures to be used for selecting the panels.

175.43(2) *Membership of panels.* Each panel established shall be composed of a multidisciplinary team of volunteer members who are broadly representative of the community in which the panel is established, including members who possess knowledge and skills related to the diagnosis, assessments, and disposition of child abuse cases, and who have expertise in the prevention and treatment of child abuse. The membership of each panel shall include professionals practicing in the disciplines of medicine, nursing, public health, substance abuse, domestic violence, mental health, social work, child development, education, law, juvenile probation, law enforcement; or representatives from organizations that advocate for the protection of children. The panel shall function under the leadership of a chairperson and vice-chairperson who are elected annually by the membership. Members shall enter into a contract with the department.

175.43(3) *Meetings.* Each panel established pursuant to this rule shall meet not less than once every three months.

175.43(4) *Functions.* Each panel established pursuant to this rule shall:

a. Evaluate the extent to which the department effectively discharges the child protection responsibilities in accordance with: the state plan and the child protection standards under subsection (b) of the Child Abuse Prevention and Treatment Act of 1996; the child protection duties of the department set forth in Iowa Code chapters 232 and 235A; and any other criteria that the panel considers important to ensure the protection of children, including:

(1) A review of the extent to which the child protective services system is coordinated with the foster care and adoption programs established under Part E of Title IV of the Social Security Act (42 U.S.C.S. 670 et seq.); and

(2) A review of child fatalities and near fatalities.

b. Provide for public outreach and comment in order to:

(1) Assess the impact of current procedures and practices upon children and families in the community; and

(2) Make recommendations to the state and the public on improving the child protective services system at the state and local levels.

175.43(5) *Redissemination.* No panel member shall redisseminate child abuse information obtained through the citizen review panel. This shall not preclude redissemination of information as authorized by Iowa Code section 235A.17 when an individual panel member has received information as a result of another authorized access provision of the Iowa Code.

175.43(6) *Department not bound.* The department shall consider the recommendations of the panel but shall not, in any way, be bound by the recommendations.

175.43(7) *Confidentiality.* Members and staff of a panel may not disclose child abuse information about any specific child abuse case to any person or government official and may not make public any information unless authorized by the Iowa Code to do so.

175.43(8) *Reports.* Each panel established under this rule shall prepare and make available to the public, on an annual basis, a report containing a summary of the activities of the panel.

175.43(9) *Staff assistance.* The department shall provide staff assistance to citizen review panels for the performance of their duties, upon request of the panel.

175.43(10) *Access to child abuse information.* Citizen review panels shall be under contract to carry out official duties and functions of the department and have access to child abuse information according to Iowa Code section 235A.15 [2*"e"*(2)].

[**ARC 1156C**, IAB 10/30/13, effective 1/1/14]

These rules are intended to implement Iowa Code sections 232.68, 232.71D, 232.67, 232.69, 232.70, 232.71B, 232.71C, and 232.72 to 232.77 and Iowa Code chapter 235A.

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1 Effective date of amendments to subrule 175.8(4), paragraph *"a,"* subparagraphs (7), (9), and (10); subrule 175.8(5); rules 175.9 and 175.15 delayed 70 days by the Administrative Rules Review Committee.

2 Effective date of 175.25(4)*"d"* delayed 70 days by the Administrative Rules Review Committee at its meeting held January 3, 1996; delay lifted by the Committee at its meeting held February 5, 1996, effective February 6, 1996.

[3] Effective date of amendments adopted in ARC 7975A delayed 70 days by the Administrative Rules Review Committee at its meeting held June 9, 1998.

CHAPTER 176
DEPENDENT ADULT ABUSE

[Prior to 7/1/83, Social Services[770] Ch 156]
[Previously appeared as Ch 156—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

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441—176.1(235B) Definitions.

"Assault" means the same as defined in Iowa Code section 708.1.

"At-risk adult" means a dependent adult whose personal health or safety is at risk due to impairments, the environment, a substance use disorder, a lack of services or social supports, a refusal to accept services, or other risk factors identified through an assessment.

"Caretaker" means the same as set forth in Iowa Code section 235B.2.

"Collateral sources" means any agency or person who is providing, either in a professional or paraprofessional capacity, service to the dependent adult, including but not limited to doctors, counselors, and public health nurses.

"Denial of critical care" exists when the dependent adult's basic needs are denied or ignored to such an extent that there is imminent danger of the dependent adult suffering injury or death.

"Dependent adult" means the same as set forth in Iowa Code section 235B.2.

"Dependent adult abuse" means the same as set forth in Iowa Code section 235B.2.

"Expungement" means the process of permanently deleting electronic and printed materials regarding dependent adult abuse information in compliance with Iowa Code section 235B.9.

"Finding" means the department's determination, following an investigation, of whether dependent adult abuse or self-neglect occurred.

"Immediately" means within 24 hours when referring to mandatory reporters reporting suspected abuse of a dependent adult.

"Imminent" means occurring or likely to occur soon.

"Investigation" means the process of examining and gathering information about an allegation of dependent adult abuse to determine if the circumstances of the allegation meet the standards of evidence for a finding.

"Investigative summary" means the written documentation of an investigation that summarizes the information gathered, including all actions taken or contemplated, the analysis of the evidence, and the finding of whether dependent adult abuse or self-neglect occurred.

"Multidisciplinary team" means a membership of individuals who possess knowledge and skills related to the diagnosis, assessment, and disposition of dependent adult abuse cases and who are professionals practicing in the disciplines of medicine, public health, social work, law, law enforcement and other disciplines relative to dependent adults.

"Physical injury" means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue that results in the death of the person who has sustained the damage, or physical injury that is at variance with the history given of it.

"Registry" means the central registry for dependent adult abuse information established in Iowa Code section 235B.5.

"Report" means a verbal or written statement, made to the department, that alleges that dependent adult abuse has occurred.

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.2(235B) Denial of critical care. A finding of denial of critical care shall be made only when the caretaker or dependent adult had the financial ability to obtain the necessary critical care need or when financial or other reasonable means were offered and the caretaker or dependent adult refused or failed to utilize them. It includes the failure, by the act or omission on the part of the caretaker or the dependent

adult, to provide minimum food, shelter, clothing, supervision, physical care, mental health care, or other care necessary to maintain the dependent adult's health and welfare when financially able to do so or when offered financial or other reasonable means to do so.
[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.3(235B) Appropriate report. Upon receipt of a dependent adult abuse report, the department will conduct an intake sufficient to determine whether the allegation meets criteria and constitutes a report of dependent adult abuse as defined in Iowa Code section 235B.2.

176.3(1) Abuse reports. Dependent adult abuse reports will be investigated when all of the following criteria are alleged to be met:

a. There is a reasonable belief the person is a dependent adult.

b. Dependent adult abuse as defined in Iowa Code section 235B.2 is suspected.

c. The alleged person responsible is:

(1) A caretaker in reports of physical injury, assault, unreasonable confinement or cruel punishment of a dependent adult; commission of a sexual offense; exploitation; personal degradation; and deprivation of food, shelter, clothing, supervision, physical or mental health care and other care necessary to maintain life or health.

(2) The dependent adult in reports of deprivation of food, shelter, clothing, supervision, physical or mental health care and other care necessary to maintain life or health due to the adult's own acts or omissions pursuant to Iowa Code section 235B.2(5)*"a."*

176.3(2) Nondependent adult abuse situations. In addition to the circumstances established in Iowa Code section 235B.2(5)*"b,"* the following are also not dependent adult abuse situations:

a. A report of domestic abuse under Iowa Code chapter 236 does not in and of itself constitute a report of dependent adult abuse.

b. An allegation pertaining to correctional staff as caretakers when the alleged victim is a person legally incarcerated in a penal setting, either in a local jail or confined to the custody of the director of the department of corrections.

176.3(3) Dependent adult acts or omissions. The investigative summary of dependent adult abuse that is the result of the acts or omissions of the dependent adult will be collected and maintained as set forth in Iowa Code section 235B.3(1)*"b."*

176.3(4) Confirmed, not registered finding. Physical abuse, denial of critical care by a caretaker, or personal degradation investigative summaries that would otherwise be founded will be classified as confirmed, not registered if the abuse is determined to be minor, isolated, and unlikely to reoccur. Such investigative summaries will not be included on the registry. Access to confirmed, not registered dependent adult abuse information will be authorized pursuant to Iowa Code section 235B.6(3).
[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.4(235B) Reporters. As a function of the registry, the department will take reports from mandatory reporters or any other person who believes dependent adult abuse has occurred.

176.4(1) Mandatory reporters shall report suspected abuse of a dependent adult within 24 hours of becoming aware of an abusive incident.

176.4(2) The reporter may use a department-prescribed form or a form developed by the reporter that meets the requirements of Iowa Code section 235B.3.
[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.5(235B) Reporting procedure.

176.5(1) Each report made may be orally or in writing to the department.

176.5(2) When the person making the report has reason to believe that immediate protection for the dependent adult is advisable, that person will be asked to also make an oral report to an appropriate law enforcement agency.

176.5(3) The department will provide access to all reports alleging dependent adult abuse to the appropriate county attorney.

176.5(4) The report may contain the following information, or as much thereof as the person making the report is able to furnish:

a. The names and home addresses of the dependent adult, appropriate relatives, caretakers, and other persons believed to be responsible for the care of the dependent adult.

b. The dependent adult's present whereabouts if not the same as the address given.

c. The reason the adult is believed to be dependent.

d. The dependent adult's age.

e. The nature and extent of the dependent adult abuse, including evidence of previous dependent adult abuse.

f. Information concerning suspected dependent adult abuse of other dependent adults in the same residence.

g. Other information that the person making the report believes might be helpful in establishing the cause of the abuse or the identity of the person or persons responsible for the abuse, or helpful in providing assistance to the dependent adult.

h. The name and address of the person making the report.

176.5(5) A report will be received whether or not it contains all of the information requested in subrule 176.5(4) and may be made to the department, county attorney, or law enforcement agency. When the report is made to any agency other than the department, that agency shall promptly refer the report to the department.

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.6(235B) Duties of the department upon receipt of report.

176.6(1) When a report is received and meets the criteria pursuant to Iowa Code section 235B.2(5) *"a,"* the department will promptly commence an investigation, except that the department of inspections, appeals, and licensing is responsible for the investigation and disposition of a case of dependent adult abuse in a health care facility pursuant to Iowa Code chapter 235E, including hospitals as defined in Iowa Code section 135B.1 and facilities as defined in Iowa Code section 135C.1. The department will forward all reports and other information concerning dependent adult abuse in a health care facility to the department of inspections, appeals, and licensing on the first working day following the submission of the report.

176.6(2) The investigative summary will include all of the following:

a. Identification of the nature, extent, and cause of the dependent adult abuse, if any, to the dependent adult named in the report.

b. The identity of the person or persons responsible for the dependent adult abuse.

c. An examination of whether other dependent adults in the same residence have been subjected to dependent adult abuse.

d. A critical explanation of all other statutory requirements outlined in Iowa Code chapter 235B.

176.6(3) With the consent of the dependent adult or caretaker, investigations may include a visit to the residence of the dependent adult named in the report and an examination of the dependent adult.

a. If permission to enter the residence and to examine the dependent adult is refused, the district court, upon a showing of probable cause that a dependent adult has been abused, may authorize a person, authorized by the department, to enter the residence of and to examine the dependent adult.

b. Upon a showing of probable cause that a dependent adult has been financially exploited, a court may authorize a person, also authorized by the department, to gain access to the financial records that the department reasonably believes are related to the resources of the dependent adult.

176.6(4) Completion of investigation. Upon completion of the investigation, the department will complete a written investigative summary that describes its findings and includes all actions taken or contemplated.

a. The department will complete its investigative summary within 20 business days of the receipt of the reported abuse allegations unless an extension of time for good cause is granted. The department may grant an extension for a maximum of 30 business days. No more than three extensions will be granted.

b. Upon completion of an investigation, the department will enter its investigative summary into the electronic dependent adult reporting and evaluation system (DARES).

176.6(5) Investigative summary to county attorney. The department will provide access to the investigative summary to the appropriate county attorney.

176.6(6) During the investigation, the department will complete an assessment of services needed by a dependent adult believed to be the victim of abuse, the dependent adult's family, or a caretaker. The department will explain that the department does not have independent legal authority to compel the acceptance of protective services. Upon voluntary acceptance of the offer of services, the department will make referrals or may provide necessary protective services to eligible dependent adults, family members, and caretakers.

176.6(7) Notification of licensing authority. Based on information discovered during an investigation of dependent adult abuse in a program providing care to a dependent adult as authorized pursuant to Iowa Code section 235B.6(2)*"c"* and for the purpose of assuring safety and mitigating risk to dependent adults, the department will notify the licensing or accrediting authority for the program, the governing body of the program, and the administrator in charge of the program of any of the following occurs:

a. A violation of program policy noted in the investigation.

b. An instance in which program policy or lack of program policy may have contributed to the dependent adult abuse.

c. An instance in which general practice in the program appears to differ from the program's policy.

176.6(8) Services by other agencies. The department may approve agencies considered capable and appropriate to provide services during the course of an investigation to dependent adults who are suspected of being abused or neglected.

a. The department may make a referral to an approved agency to provide services to a dependent adult who is suspected of being abused or neglected in conjunction with an abuse investigation on the dependent adult.

b. The department may use information obtained during services provided by the approved agency in the abuse investigation. The department has complete authority in determining the conclusions of the abuse investigation.

176.6(9) Assessment of dependency and risk. During a dependent adult abuse investigation, the department will complete an assessment of the adult pursuant to Iowa Code section 235B.16A(2). The department will assess:

a. The adult's dependency,

b. The risk to the adult's health or safety, and

c. The areas in which the adult is either dependent or independent.

176.6(10) Follow up for at-risk adults. When it has not been possible or necessary to obtain a court order for services to an at-risk adult, the department will attempt to empower the at-risk adult to agree to accept services or to participate in developing a plan to mitigate risk and safety on a form prescribed by the department. If the at-risk adult refuses to develop a plan to mitigate risk and safety or to accept recommended services, the department will provide periodic visits at the conclusion of the investigation. Periodic visits will be conducted with the at-risk adult. The department has no authority to share information or obtain information with any other individuals during the course of periodic visits. Periodic visits should not be used as a means to continue gathering investigation information.

a. Purpose. The purpose of the periodic visits will be to:

(1) Assess the at-risk adult for increased risk or impairment,

(2) Monitor the at-risk adult's situation to determine the feasibility of intervening with protective services, and

(3) Empower the at-risk adult to accept recommended services or to engage in developing a plan to mitigate risk and safety.

b. Exemption. If it has been determined there is a physical threat to the safety of the department employee who is attempting to visit an at-risk adult, the department will not attempt a periodic visit unless the physical threat to safety has been removed.

c. Considerations to continue periodic visits from one month to the next. Periodic visits will continue if:

(1) The at-risk adult's health or safety has deteriorated somewhat but not to the point that a court order is necessary; or

(2) The at-risk adult's health or safety has remained the same and there is a possibility the at-risk adult may in the future agree to services or participate in developing a plan to mitigate risk and safety.

d. *Criteria to end periodic visits.* Periodic visits will be terminated when:

(1) The at-risk adult agrees to services and services are arranged;

(2) The at-risk adult agrees to the development of a plan to mitigate risk and safety;

(3) The at-risk adult's health or safety has deteriorated to the point that the department has requested court action;

(4) A new allegation of abuse is accepted; or

(5) The at-risk adult's health or safety has not changed for three months after the conclusion of the investigation and there appears no possibility the adult will ever agree to services.

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.7(235B) Investigation.

176.7(1) After receipt of a report alleging dependent adult abuse that meets criteria as outlined in subrule 176.3(1), a dependent adult abuse investigation will be initiated and will be assigned to a department employee. The department will make an effort to observe and examine the dependent adult and evaluate the dependent adult's safety.

a. When report information indicates an immediate risk of death, immediate risk of serious or irreparable harm, or immediate risk of significant loss of income, assets, or resources to the dependent adult, the initial response will occur no later than 24 hours after receipt of a report of dependent adult abuse.

b. When report information does not indicate an immediate risk of death, serious or irreparable harm, or significant loss of income, assets, or resources, the initial response will occur no later than 72 hours after receipt of a report of dependent adult abuse.

c. When reasonable efforts have been made to observe the adult subject within the specified time frames and the department has established that there is no need to observe and no risk to the adult subject, the observation of the adult subject may be delayed or waived with supervisory approval.

176.7(2) After receipt of the report alleging dependent adult abuse, the department employee will conduct an investigation to determine whether the information as reported, other known information, and any information gathered as a result of the worker's contact with collateral sources or other collateral contacts would tend to corroborate the alleged abuse.

176.7(3) If, following acceptance of a report, information obtained during initial case activity establishes that the report was accepted on materially inaccurate reported facts and does not fall within the scope of Iowa Code chapter 235B, the department employee may, with department approval, terminate the investigation and submit the investigative summary. In such cases, completion of assessments required under Iowa Code section 235B.16A is not required.

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.8(235B) Registry records. Registry records will be kept in the name of the dependent adult and cross-referenced in the name of the alleged person responsible (if applicable).

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.9(235B) Dependent adult abuse information disseminated.

176.9(1) *Requests for information.* Written requests for dependent adult abuse information by the subject of a report may be submitted to the county office of the department on the department-prescribed forms.

a. Oral requests for dependent adult abuse information may be made to the county office or the registry when the person making the request believes that the information is needed immediately and the person is authorized to access the information, pursuant to the requirements of Iowa Code section 235B.6.

b. If a request is made orally by telephone, a written request shall be filed within 72 hours of the oral request on the department-prescribed form. When an oral request to the county office to obtain dependent

adult abuse information is granted by the registry, the county shall document the approval to the registry on the department-prescribed form.

c. All other requests for information shall be made to the registry in writing pursuant to the requirements of Iowa Code section 235B.7.

176.9(2) *Verification of identity.* The county office will verify the identity of the person making the request on the department-prescribed form. Upon verification of the identity of the person making the request, the county office will transmit the request to the registry. The registry will verify the identity of persons making requests for information directly to the registry by telephone, mail, or fax, or in person on the appropriate department-prescribed form.

176.9(3) *Approval of requests.* The department will grant access to dependent adult abuse information as authorized by Iowa Code section 235B.6. Upon approval of any request for dependent adult abuse information authorized by this rule, the department may withhold the name of the person who made the report of dependent adult abuse pursuant to Iowa Code section 22.7(18).

176.9(4) *Requests concerning applicants for employment and employees of health care programs.* A health care program making a request for dependent adult abuse information for the purpose of determining employability, as authorized by Iowa Code section 235B.6(2)*"e"*(6) and *"e"*(7), shall request the information directly from the registry or obtain the information from the single contact repository (SING).

176.9(5) *Requests concerning employees of department facilities.* The department may conduct periodic background checks as needed. The department will inform the hiring authority only upon a finding that the results of a background check have a direct bearing on employability of the person employed. When the personnel office determines that the information has no direct bearing on employability, the hiring authority will be notified that no job-related dependent adult abuse information is available. If the registry and local office files contain no information, the hiring authority will be so informed.

176.9(6) *Dependent adult abuse information disseminated and redisseminated.* Notwithstanding requests pursuant to Iowa Code section 235B.7, written requests and oral requests are not required for dependent adult abuse information that is disseminated to an employee of the department, a district court, the attorney representing the department as authorized by Iowa Code section 235B.6, or the office of the attorney general.

176.9(7) *Required notification.* The department will make a reasonable attempt to notify dependent adult abuse subjects as described in Iowa Code section 235B.6(2)*"a"* of the outcome of the dependent adult abuse investigation. The department shall subsequently send a written notice to the report subjects that will include information regarding the finding, the confidentiality provisions of Iowa Code sections 235B.6 and 235B.12, and the procedures for correction or expungement and appeal of dependent adult abuse information as provided in Iowa Code section 235B.10.

176.9(8) *Reporter notification.* Following the reporting of suspected dependent adult abuse, the department will inform the mandatory or permissive reporter, orally or by other appropriate means, whether the department commenced an investigation or if the concern was referred to another agency.

176.9(9) *Subjects informed of abuse history.* The department may inform a subject of a dependent adult abuse investigation of a person's abuse history if the department determines at any time that disclosure is necessary for the protection of the dependent adult. A subject may be informed that a person is listed on the child or dependent adult abuse registry as having a finding of founded abuse or is listed on the sex offender registry.

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.10(235B) Examination of information. Pursuant to Iowa Code section 235B.10, any person, or that person's attorney, requesting to examine the information in the registry that refers to that person shall be allowed to inspect the information after providing appropriate identification.

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.11(235B) Dependent adult abuse information registry. The department will create a central abuse registry for dependent adult abuse information. The registry will collect, retain, and disseminate dependent adult abuse information from DARES as described in Iowa Code section 235B.9.

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.12(235B) Multidisciplinary teams.

176.12(1) *Purpose of multidisciplinary teams.* The department will establish multidisciplinary teams for the purpose of assisting the department in assessment, diagnosis, and disposition of reported dependent adult abuse cases. The disposition of a case may include the provision for treatment recommendations and services.

176.12(2) *Execution of team agreement.* When the team is established, the department and all team members shall execute an agreement on a form prescribed by the department.

a. The team will be consulted solely for the purpose of assisting the department in the assessment, diagnosis, and treatment of dependent adult abuse cases.

b. Any team member may cause a dependent adult abuse case to be reviewed if approved by the department.

c. No team members shall redisseminate dependent adult abuse information obtained solely through the multidisciplinary team. This shall not preclude redissemination of information as authorized by Iowa Code section 235B.6 when an individual team member has received information as a result of another authorized access provision of the Iowa Code.

d. The department may consider the recommendation of the team in a specific dependent adult abuse case but will not be bound by the recommendations.

e. Any document produced by the team pertaining to an individual case shall be made a part of the file for the case and shall be subject to all confidentiality provisions of Iowa Code sections 235B.6 and 235B.8.

f. Any written records maintained by the team that identify an individual dependent adult abuse case shall be destroyed when the agreement lapses.

g. Consultation team members shall serve without compensation.

h. Any party to the contract may withdraw with or without cause upon the giving of 30 days' notice.

i. All agreements must include the date on which the agreement will expire.

176.12(3) *Filing of agreement.* Whenever a team is created, a copy of the executed agreement will be kept by the department, in addition to any other requirements placed upon execution of the agreement by the department.

[**ARC 0774D**, IAB 11/25/26, effective 1/1/27]

441—176.13(235B) Request for correction or expungement. The department is responsible for correction or expungement of investigative summaries prepared by department staff. The department of inspections, appeals, and licensing is responsible for correction or expungement of investigative summaries prepared by that department's staff.

176.13(1) When a request for correction or expungement pursuant to Iowa Code section 235B.10 is received by the registry, the registry will record the request and promptly forward it to the appropriate area for review. The determinations made will be binding on the registry.

176.13(2) Unless the designated department corrects the information or findings as requested, the designated department shall provide the person making the request with an opportunity for a hearing as provided by 441—Chapter 2506 to correct the information or the findings. The department may defer the hearing until the conclusion of a pending district court case relating to the information or findings.

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CHAPTER 177
IN-HOME HEALTH-RELATED CARE

[Prior to 7/1/83, Social Services[770] Ch 148]
[Previously appeared as Ch 148—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services [498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/31

441—177.1(249) Definitions.

"Nursing care" includes skilled services and personal care services.

"Own home" means an individual's house, apartment, or other living arrangement intended for single or family residential use.

"Personal care services" includes:

1. Services that assist a client with the activities of daily living, such as but not limited to helping the client with bathing, toileting, getting in and out of bed, ambulation, hair care, oral hygiene and administering medications that are physician-ordered but ordinarily self-administered.
2. Services that help or retrain the client in necessary skills for daily living.
3. Incidental household services that are essential to the client's health care at home and are necessary to prevent or postpone institutionalization.

"Skilled nursing services" are services for which an individualized assessment of a patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse (skilled care) are necessary.

"Skilled services" include skilled nursing services or other services that, based on a physician's certification, are required to be performed under the supervision of a physician, nurse practitioner, clinical nurse specialist, or physician associate.

"Supervising practitioner" means a physician, nurse practitioner, clinical nurse specialist, or physician associate qualified to supervise skilled services.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

441—177.2(249) Eligibility and application.

177.2(1) *Eligibility.* To be eligible for in-home health-related care (IHHRC):

a. The individual must be eligible for supplemental security income (SSI) in every respect, except for income.

b. A physician must certify in accordance with rule 441—177.5(249) that the individual requires either skilled services or personal care services and that those services can be provided in the individual's own home. The certification shall be provided using a form prescribed by the department.

c. The individual shall live in the individual's own home. Notwithstanding the foregoing, an individual will remain eligible for a period not to exceed 15 days in any calendar month when the client is temporarily absent from the client's home.

d. The individual shall obtain a physical examination report annually and shall be under the supervision of a physician.

e. The required skilled services or personal care services must not be available under any other state or federal program.

f. The countable income of the individual and spouse living in the home shall be limited to $480.55 per month if one needs care or $961.10 if both need care, after the following disregards from gross income:

(1) The amount of the basic SSI standard for an individual or a couple, as applicable.

(2) When income is earned, $65 plus one-half of any remaining income.

(3) The amount of the SSI standard for a dependent plus any established unmet medical needs for each dependent living in the home. Any income of the dependent shall be applied to the dependent's needs before making this disregard.

(4) The amount of the established medical needs of the ineligible spouse that are not otherwise met.

(5) The amount of the established medical needs of the applicant or recipient that are not otherwise met and would not be met if the individual were eligible for the medical assistance program.

g. Income for children.

(1) All income received by the parents in the home shall be deemed to the child with the following disregards:

1. The amount of the basic SSI standard for an individual when there is one parent in the home or for a couple when there are two parents in the home.
2. The amount of the basic SSI standard for a dependent for each ineligible child in the home.
3. The amount of the unmet medical needs of the parents and ineligible dependents.
4. When all income is earned, an additional basic SSI standard for an individual in a one-parent home or for a couple in a two-parent home.
5. When the income is both earned and unearned, $65 plus one-half of the remainder of the earned income.

(2) The countable income of the child shall be limited to $480.55 per month after the following disregards from gross income:

1. The amount of the basic SSI standard for an individual.
2. The amount of the established medical needs of the child that are not otherwise met and would not be met if the child were eligible for the medical assistance program.
3. One-third of the child support payments received from an absent parent.

177.2(2) *Application.* Application for IHHRC shall be made on a form prescribed by the department and submitted to the department. An eligibility determination will be completed within 30 days from the date of the application unless one or more of the following conditions exist:

a. An application has been filed and is pending for federal SSI benefits.

b. The application is pending because the department has not received information that is beyond the control of the client or the department.

c. The application is pending due to the disability determination process performed through the department.

d. The application is pending because the provider agreement has not been completed and completion is beyond control of the client. When the provider agreement cannot be completed due to the client's failure to locate a provider, applications will not be held pending beyond 60 days from the date of application.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

441—177.3(249) Qualifications of providers of health care services.

177.3(1) *Age.* The provider shall be at least 18 years of age.

177.3(2) *Health assessment.* The provider shall obtain certification on a form prescribed by the department that the provider is physically and emotionally capable of providing assistance to another person whose physical, developmental or mental health prevents independent self-care.

a. The certification shall be based on an examination performed by:

(1) A physician; or

(2) An advanced registered nurse practitioner or physician associate if the advanced registered nurse practitioner or physician associate is working under the direction of a physician.

b. If the provider works for an agency, the practitioner performing the examination may not be employed by the same agency.

c. The practitioner conducting the examination shall sign the certification.

d. The certification shall be submitted to the department:

(1) Before the provider agreement is signed, and

(2) Annually thereafter.

177.3(3) *Qualifications.* The provider shall be qualified by training and experience to carry out the health care plan as specified in subrule 177.6(1).

177.3(4) *Relative.* The provider may be related to the client, so long as the provider is not the client's:

a. Legal spouse, including a common law spouse, who resides in the same household.

b. Natural mother or father, adoptive mother or father, or stepmother or stepfather, who resides in the same household.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

441—177.4(249) Physician's certification.

177.4(1) *Certification requirements.* A physician must certify on a form provided by the department:

a. That the skilled services or personal care services are required by the person's physical, developmental or mental health;

b. The specific skilled services or personal care services required, the method of providing those services, and the expected duration of those services; and

c. That the required skilled services and personal care services can be delivered in the individual's own home.

177.4(2) *Certification review.* After certification and any subsequent recertification, a physician must review the certification and withdraw, renew, or amend the existing certification:

a. No later than the three hundred sixty-fifth day after the existing certification;

b. More frequently than yearly after the existing certification if required by the physician, the department, or a supervising practitioner; or

c. Upon notification of initiation of Medicaid waiver services.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

441—177.5(249A) Department duties.

177.5(1) *Service plan.*

a. In consultation with the client's case manager and any supervising health practitioner, the department will create a complete service plan for the client. The plan must avoid duplication of services and include all of the following:

(1) All of the services certified by a physician under rule 441—177.4(249).

(2) Payer sources. IHHRC care shall be provided only when other programs cannot meet the client's needs.

(3) Level of service needs.

(4) Service history. If the client is being transferred from a medical hospital or long-term care facility, the department will also obtain a transfer document describing the client's current care plan.

b. In consultation with the client's case manager and any supervising health practitioner, the department will review and update the service plan on or before the ninetieth day following the creation of or previous review of the service plan. The updated service plan must comply with paragraph 177.5(1)*"a."*

177.5(2) *Change in condition.* If the department becomes aware of any changes in the individual's condition, including discharge from a facility, that could require a change in the services provided, the department will ensure that a physician reviews the existing certification and that the existing certification is withdrawn, renewed, or amended.

177.5(3) *Service documentation.*

a. The department will review the service documentation submitted by the client or provider, including any requests for supplementation of services.

b. If there are concerns as a result of such a review, there will be a change in the service plan.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

441—177.6(249) Supervising practitioner duties.

177.6(1) *Instruction.* The supervising practitioner shall provide instruction specific to each patient and the services each patient is receiving, including but not limited to instruction on documentation the worker should be creating and instruction on warning signs of which the department should be aware.

177.6(2) *Schedule for reviewing documentation.* The supervising practitioner shall set up a schedule for reviewing documentation that is specific to the services being provided to that particular patient and shall review the documentation according to the schedule.

177.6(3) *Medical records.*

a. The supervising practitioner shall keep appropriate medical records, a copy of the service plan, and the physician's certification in the supervising practitioner's case file. In addition, the medical records shall include, whenever appropriate, transfer forms, physician's orders, progress notes, drug administration records, treatment records, and incident reports.

b. The supervising practitioner shall make all medical records available to the department, the client, and the client's legal representative.

c. The supervising practitioner shall ensure that, upon termination of the in-home care plan, the medical records are transferred to the department.

d. The department will retain medical records transferred to it under paragraph 177.6(3)*"c"* for five years or, if an audit is commenced within the five years, until completion of that audit.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

441—177.7(249) Written agreements.

177.7(1) *Independent contractor.* The provider shall be an independent contractor and shall not be an agent, employee or servant of the state of Iowa, the department or any of its employees or clients.

177.7(2) *Liability coverage.* All professional health care providers shall have adequate liability coverage consistent with the professional health care providers' responsibilities, since the department assumes no responsibility, or liability, for individuals providing care.

177.7(3) *Provider agreement.*

a. The client and the provider shall enter into an agreement using a form prescribed by the department prior to the provision of service. Any reduction to the state supplemental assistance program shall be applied to the maximum amount paid by the department as stated in the provider agreement by using the separate amendment to provider agreement form.

b. Written instructions for dealing with emergency situations will be completed by the department and included in the provider agreement, which shall be maintained in the client's home and at the department. The instructions will include:

(1) The name and telephone number of the client's physician, responsible family members or other significant persons;

(2) Information as to which hospital to utilize; and

(3) Information as to which ambulance service or other emergency transportation to utilize.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

441—177.8(249) Payment.

177.8(1) *Payment approved.* Notwithstanding 42 U.S.C. §1382(c)(7) as amended to August 1, 2026, after the department approves the service plan, payment is effective as of the later of (1) the date of the application or (2) the date all eligibility requirements are met and qualified health care services are provided.

177.8(2) *Client participation.*

a. Except as provided in paragraph 177.8(2)*"b,"* all income remaining after excluding the amounts identified in paragraphs 177.2(1)*"f"* and *"g"* will be considered income available for services (client participation) and the IHHRC program will pay only the cost of eligible services that exceeds client participation up to the maximum benefit payable.

b. When the first month of service is less than a full month, there is no client participation for that month. Payment will be made for the actual days of service provided according to the agreed-upon rate up to the maximum benefit payable.

177.8(3) *Maximum benefit payable.* The maximum benefit payable for IHHRC services inclusive of all services for all providers is the reasonable charges for such services up to and including $480.55. The provider shall accept the maximum benefit payable and shall not charge the client or others in excess of that benefit.

177.8(4) *Payment.* The client or the person legally designated to handle the client's finances shall be the sole payee for payments made under the program and shall be responsible for making payment to the provider except when the client payee becomes incapacitated or dies while receiving service.

a. The department will have the authority to issue one payment to a provider on behalf of a client payee who becomes incapacitated or dies while receiving service.

b. When continuation of an incapacitated client payee in the program is appropriate, the department will assist the client and the client's family to legally designate a person to handle the client's finances.

Guardians, conservators, protective or representative payees, or persons holding financial power of attorney are considered to be legally designated.

c. If the client has a temporary absence from home, payment will not be authorized for over 15 days for any continuous absence whether or not the absence extends into a succeeding month or months.

177.8(5) *Reasonable charges.* Payment will be made only for reasonable charges for in-home health care services as determined by the department, which will determine reasonableness by:

a. The prevailing community standards for cost of care for similar services.

b. The availability of services at no cost to the IHHRC program.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

441—177.9(249) Termination conditions. Termination of IHHRC will occur under the following conditions.

177.9(1) *Request.* When the client or the client's legal representative requests termination.

177.9(2) *Care unnecessary.* When the client becomes sufficiently able to remain in the client's own home with services that can be provided by other sources as determined by the department.

177.9(3) *Additional care necessary.* When the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the department in consultation with the certifying physician.

177.9(4) *Excessive costs.* When the cost of care exceeds the maximum established in subrule 177.9(3).

177.9(5) *Other services utilized.* When the department determines that other services can be utilized to better meet the client's needs.

177.9(6) *Terms of provider agreement not met.* When it has been determined by the department that the terms of the provider agreement have not been met by the client or the provider, the state supplementary assistance payment may be terminated.

177.9(7) *Failing to comply with program requirements.* When the recipient is not following the program requirements or cooperating with the program objectives, including but not limited to a failure to provide documentation to program representatives.

177.9(8) *Notice and appeal.* Written notice of termination will be provided pursuant to 441—Chapter 16. The decision may be appealed pursuant to 441—Chapter 2506.

[**ARC 0460D**, IAB 8/5/26, effective 10/1/26]

These rules are intended to implement Iowa Code section 249.3(2)*"a"*(2).

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CHAPTER 178
Reserved

CHAPTER 179
WRAP-AROUND FUNDING PROGRAM
Rescinded IAB 7/11/01, effective 7/1/01

CHAPTER 180
RESPITE CARE SERVICES
Rescinded IAB 6/8/05, effective 7/1/05

CHAPTER 181
FAMILY PRESERVATION SUPPORTIVE AND NONREHABILITATIVE TREATMENT SERVICES
Rescinded IAB 4/11/07, effective 7/1/07

CHAPTER 182
FAMILY-CENTERED SERVICES
[Prior to 2/11/87, Human Services[498]]
Rescinded IAB 5/6/09, effective 7/1/09

CHAPTER 183
ADULT SUPPORT PROGRAM
[Prior to 9/23/87, see Human Services Department[441] Chs 178 and 179]
Rescinded IAB 5/6/09, effective 7/1/09

CHAPTER 184
INDIVIDUAL AND FAMILY DIRECT SUPPORT
Rescinded **ARC 0397D**, IAB 6/24/26, effective 8/1/26

CHAPTER 185
REHABILITATIVE TREATMENT SERVICES
Rescinded IAB 5/6/09, effective 7/1/09

CHAPTER 186
COMMUNITY CARE
Rescinded **ARC 5248C**, IAB 11/4/20, effective 1/1/21

CHAPTER 187
AFTERCARE SERVICES PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/32

441—187.1(234) Aftercare services program eligibility requirements. To be eligible for aftercare services, a youth needs to meet the following requirements.

187.1(1) *Residence.* The youth must be a resident of Iowa.

187.1(2) *Age.* The youth must be at least 17 years of age but less than 23 years of age.

187.1(3) *Out-of-home placement experience.*

a. *Preservices.* The youth must meet eligibility requirements for preservices as described below:

(1) The youth is at least 17 years of age;

(2) The youth is placed in foster care, the state training school, or a court-ordered Iowa juvenile detention center; was adopted from foster care after reaching 16 years of age; or entered a subsidized guardianship arrangement from foster care after reaching 16 years of age; and

(3) The youth has access to funding for preservices provided in contract that has not been fully expended for the contract year.

b. *Core services.* The youth must meet eligibility requirements for core services as described below:

(1) The youth is 18, 19, or 20 years of age; and

(2) The youth exited foster care, the state training school, or a court-ordered Iowa juvenile detention center:

1. On or after the youth's eighteenth birthday;
2. Between the ages of 17½ and 18 after having been in any combination of foster care, the state training school, or a court-ordered Iowa juvenile detention center for at least one day in at least 6 of the 12 calendar months prior to the youth leaving placement; or

(3) The youth was adopted from foster care on or after the youth's sixteenth birthday; or

(4) The youth entered a subsidized guardianship arrangement from foster care on or after the youth's sixteenth birthday.

c. *Extended services.* The youth must meet eligibility requirements for extended services as described below:

(1) The youth resides in Iowa;

(2) The youth is 21 or 22 years of age; and

(3) The youth has access to funding for extended services provided in contract that has not been fully expended for the contract year.

d. *Definition of foster care.* For purposes of this chapter, "foster care" is defined as 24-hour substitute care for a child who is placed away from the child's parents or guardians and for whom the department or juvenile court services has placement and care responsibility through either a court order or voluntary agreement.

(1) A placement may meet this definition of foster care regardless of whether:

1. The placement is licensed and the state or a local agency makes payments for the child's care;
2. Adoption subsidy payments are being made before the finalization of adoption; or
3. There is federal matching of any payments made.

(2) Foster care may include but is not limited to placement in:

1. A foster family home;
2. A foster care group home;
3. An emergency shelter;
4. Supervised apartment living;
5. A preadoptive home;
6. The home of a relative or suitable person; or
7. A psychiatric medical institution for children (PMIC).

187.1(4) *Responsibility.* The youth must:

a. Actively take part in developing and participating in an individual self-sufficiency plan; and

b. Indicate recognition and acceptance of personal responsibility in the transition toward self-sufficiency, which includes meeting with the self-sufficiency advocate regularly and as described in the youth's individual self-sufficiency plan.

[**ARC 0775D**, IAB 11/25/26, effective 1/1/27]

441—187.2(234) Services and supports provided. The aftercare services program delivered by a provider contracted by the department shall provide the following services and supports to eligible youth.

187.2(1) *Preservices.* Informational and trust-building activities may be provided to a youth placed out of home who is expected to participate in aftercare services at 18 years of age or older. The department may provide funds; however, funds provided to the youth in preservices will be deducted from available start-up funds in the youth's first year of participation in core services.

187.2(2) *Core services.* Case management services shall be offered to youth at a safe and convenient location. Activities shall include but are not limited to all of the following:

a. Development of an individual self-sufficiency plan based on an assessment of the youth's strengths and needs. Each core services participant shall have a plan to identify:

(1) The youth's goals for achieving self-sufficiency;

(2) The target date for reaching the goals; and

(3) The tasks, responsible parties, time frames, and desired outcomes needed to reach the goals.

b. Services to develop a budget and money management skills training.

c. Services to assist the youth in establishing or reestablishing relationships with significant adults.

d. Services to facilitate the youth's access to community resources.

e. Life skills training, as identified in the youth's individual self-sufficiency plan. Life skills training shall include skills to help the youth in establishing and maintaining safe and stable housing, education goals, employment goals, health and health care coverage, healthy relationships, or other life skills that the youth may need to succeed independently.

f. Additional case management activities necessary for youth to successfully transition to adulthood and as described in the individual self-sufficiency plan.

g. Individual face-to-face contact with the youth at the frequency defined in the youth's individual self-sufficiency plan and according to the youth's changing needs. If a youth is a resident of Iowa but is attending a postsecondary education program in another state, the program administrator or designee shall approve an alternative method for maintaining contact with the youth if or when it is a hardship for the youth to physically be in Iowa.

h. Ongoing assessment, including evaluation and coordination of the services, supports, and life skills training being provided to assist the youth in reaching self-sufficiency goals and to determine if and what progress is being made. The case manager shall amend any goals, outcomes, tasks, responsible parties, and time frames in the plan along with services, supports, and life skills training provided as necessary to assist the youth in achieving self-sufficiency.

187.2(3) *Extended services.* Extended services may be provided to youth, and may include life skills training, periodic check-ins, referrals to needed services, limited payments to youth, or other services determined to be valuable to the youth's development. Funds, limited to an annual per-participant amount identified in the contract, may be provided. Prior to receiving available funds, the youth is required to meet with the advocate and discuss the reason the youth is accessing funds and prior efforts to meet the need. The youth may also be asked to provide documentation of income.

187.2(4) *Start-up allowance.* When a youth between the ages of 17 and 21 is receiving or is expected to receive core services, and is actively participating in the program, the program administrator or designee may authorize and provide payment to a youth as described below:

a. The start-up allowance is intended to assist in covering the initial costs of establishing the youth's living arrangement, such as by paying rental or utility deposits, purchasing food, or purchasing necessary household items.

b. The start-up allowance is limited to amounts designated in the contract.

187.2(5) *Vendor payments.* When a youth qualifies for core services in accordance with subrule 187.3(2), and is actively participating in the program, the program administrator or designee may authorize and provide payment to a youth as described below:

a. To receive a vendor payment, the youth must demonstrate that there are no other means to meet the needs that would be covered by the vendor payment. The youth shall contribute toward the cost of meeting the identified need, to the extent the youth is able. A youth receiving a preparation for adult living (PAL) stipend, preservices, or extended services is not eligible for a vendor payment.

b. Vendor payments may include but are not limited to:

(1) Health care-related expenses;

(2) Transportation assistance;

(3) Costs related to employment and education;

(4) Clothing; and

(5) Room and board.

c. The amount available for a 12-month period of service shall be noted in the contract.

187.2(6) *PAL stipend.* When an eligible youth is actively participating in the program, the eligible youth may receive the PAL program services as described in Iowa Code section 234.46 and as follows:

a. To receive the PAL stipend, the youth must:

(1) Have met eligibility requirements in Iowa Code section 234.46(1) upon reaching the age of 18 and meet eligibility requirements in rule 441—187.1(234).

(2) Have exited foster care, the state training school, or a court-ordered Iowa juvenile detention center as identified by Iowa Code chapter 232 on or after the youth's eighteenth birthday.

(3) Meet one or more of the following criteria:

1. Be enrolled in or actively pursuing enrollment in postsecondary education, a training program, or work training; or

2. Be employed for 80 hours per month or be actively seeking that level of employment; or

3. Be attending an accredited school full-time pursuing a course of study leading to a high school diploma; or

4. Be attending an instructional program leading to a high school equivalency diploma.

b. The maximum monthly stipend shall be provided after completion of the youth's budget. The maximum amounts provided to a youth shall be stated in the contract and based on program eligibility and guidelines, as follows:

(1) The monthly stipend shall be prorated based on the number of days of youth participation for those entering and exiting the program during the month.

(2) When the monthly unearned income of the youth exceeds the overall maximum monthly stipend offered in the preparation for the adult living program, the youth is not eligible for payments unless unused startup funds remain.

(3) When the net earnings of the youth exceed the overall maximum monthly stipend offered in the PAL program, the monthly stipend is reduced by 50 cents for every dollar earned by the youth over the monthly maximum stipend.

(4) All earned and unearned income received by the youth during the 30 days before the determination shall be used to project future income. If the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(5) Nonrecurring lump-sum payments are excluded as income. Nonrecurring lump-sum payments can include one-time payments received for such things as income tax refunds, rebates, credits, refunds of security deposits on rental property or utilities, and retroactive payments for past months' benefits such as social security, unemployment insurance, or public assistance.

(6) The youth shall timely report the beginning and ending of earned and unearned income. A report is considered timely when made within ten days from the receipt of income or the date income ended.

(7) When the youth timely reports a change in income, the youth's prospective eligibility and stipend amount for the following month shall be determined based on the change.

(8) Recoupment shall be made for any overpayment due to failure to timely report a change in income or for benefits paid during an administrative appeal if the department's action is ultimately upheld. Recoupment may be made through a reasonable reduction of any future stipends.

(9) Recoupment cannot be made when a youth timely reports a change in income and the change is timely acted upon.

(10) The stipend may be paid to the youth, the foster family, or another payee other than a department employee. The payee shall be agreed upon by the parties involved and specified in the individual self-sufficiency plan.

(11) The maximum stipend may be based on the age of the youth.

187.2(7) *Extended services allowance.* A youth 21 or 22 years of age may receive extended services funds if they meet all of the following criteria:

a. The youth is participating in extended services.

b. A budget discussion has been timely completed by the youth with a self-sufficiency advocate.

c. The need has been identified in the individual self-sufficiency plan.

d. The extended services funds approved for the youth have not exceeded contracted amounts for a six-month period calculated from the date of initiation of extended services.

[**ARC 0775D**, IAB 11/25/26, effective 1/1/27]

441—187.3(234) Termination of aftercare services.

187.3(1) A youth may be discharged from the aftercare services program for any of the following reasons:

a. The youth fails to follow individual self-sufficiency plan components and expectations as determined by the program administrator or designee.

b. The youth fails to meet regularly with the self-sufficiency advocate without good cause as determined by the program administrator or designee.

c. The youth voluntarily withdraws from the program.

d. The youth is no longer a resident of Iowa.

e. The youth has entered a residential services program and has resided there for 60 days. "Residential services program" means a program where housing and support services are provided, including but not limited to homeless shelters, habilitation homes or transitional living programs.

f. The youth reaches 23 years of age.

187.3(2) Aftercare services and supports may be terminated for up to six months as determined by the program administrator or designee when a youth intentionally physically threatens or injures program staff or an employee of an aftercare provider agency.

187.3(3) The PAL stipend may be suspended or terminated if the youth fails to meet work or education eligibility requirements for 30 consecutive days without good cause as determined by the program administrator or designee.

187.3(4) The PAL stipend may be suspended or terminated if the youth fails to maintain satisfactory progress as defined by the education or training program in which the youth is enrolled. A youth who is not making satisfactory progress may stay in the PAL program component of the aftercare services program by choosing the work option.

187.3(5) The youth intentionally misrepresents income or expenditures or spends funds in a manner inconsistent with their intended purpose. The program administrator may request receipts or acceptable evidence that funds went to the intended purpose.

187.3(6) There are insufficient funds.

187.3(7) Unless otherwise stated, a youth whose aftercare service is terminated in accordance with this rule may return to the program after a minimum of at least 30 days. However, if the youth has received three or more notices of termination within a 12-month period, the youth cannot return until at least three months have passed from the date of the third notification.

[**ARC 0775D**, IAB 11/25/26, effective 1/1/27]

441—187.4(234) Waiting list. The program administrator or designee shall create a waiting list when all funds for the aftercare services program are committed for the fiscal year. Names will be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

[**ARC 0775D**, IAB 11/25/26, effective 1/1/27]

441—187.5(234) Administration. The department may contract with another state agency or a private organization to perform the administrative and case management functions necessary to administer the aftercare services program.
[**ARC 0775D**, IAB 11/25/26, effective 1/1/27]

441—187.6(234) Appeal. Notice of adverse action taken by the department shall be issued in accordance with 441—Chapter 16, and the right to appeal shall be given in accordance with 441—Chapter 2506.
[**ARC 0775D**, IAB 11/25/26, effective 1/1/27]

These rules are intended to implement Iowa Code section 234.46 and the Foster Care Independence Act of 1999.

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CHAPTERS 188 to 199
Reserved

TITLE XVI
ALTERNATIVE LIVING

CHAPTER 200
ADOPTION SERVICES

[Prior to 7/1/83, Social Services[770] Ch 139]
[Previously appeared as Ch 139—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/14/29

441—200.1(600) Definitions.

"Adoption" means a legal and social process through which a child becomes a member of a family into which the child was not born. Adoption provides the child the same rights, privileges and duties as a birth child.

"Adoption selection" means the process of making adoption placement decisions. The adoption selection committee team, tasked with making the final adoption placement decision, is made up of department of health and human service professionals. These professionals are brought together to review the child(ren)'s needs and the family's abilities to meet those needs, to make the best adoption match available and to ensure compliance with applicable adoption laws.

"Adoption selection committee team" means department staff members designated to assist in the adoption selection process. The adoption selection committee team consists of the adoption supervisor and a minimum of two adoption workers. The social work administrator (SWA) may elect to be part of the team if there is more than one family seeking to adopt the child, and the SWA may select additional department staff to serve as members of the team on a case-by-case basis.

"Adoption service" means a service directed toward children who are legally available for adoption, the birth family, prospective adoptive family, and adoptive family.

"Adoptive family" means an approved person or persons who have a child placed in their home and are being supervised prior to finalizing the adoption; or who have a child in their home who is legally adopted and entitled to the same benefits as a child born into the family.

"Adoptive home study" includes an assessment of the family's parental attributes and a written report stating approval or nonapproval of the family for adoptive placement of a child or children.

"Child study" includes a written description of the child, including strengths and needs; medical, mental, social, educational, placement and court history; a description of the child's relationships with the birth family, foster family, and significant others; a summary of the child's understanding and feeling about adoption; and recommendations as to the type of family that can best meet the child's needs.

"Child with special needs" means a child who meets one or more of the criteria set forth in 441—subrule 201.3(1).

"Court-ordered studies" means home studies ordered by a judge for the purpose of determining custody of a child or placement of a child for the purpose of adoption.

"Department" means the Iowa department of health and human services and includes the local offices of the department.

"Family-centered services" means services and other support intended to safely maintain a child with the child's family or with an adult relative; to safely and in a timely manner return a child to the home of the child's parent or relative; or to promote achievement of concurrent planning goals by identifying and helping the child secure placement for adoption, with a guardian, or with other alternative permanent family connections. Family-centered services include services adapted to the individual needs of a family regarding the specific services and other support provided to the child's family and the intensity and duration of service delivery and services intended to preserve a child's connections to the child's neighborhood, community, and family and to improve the overall capacity of the child's family to provide for the needs of the children in the family.

"Foster family adoption" means the adoption of a child by a licensed foster family that has cared for the child.

"Guardianship record" means a case record regarding a child, established and retained by the department, when the department is named guardian of the child by court order. The purpose of the guardianship record is to collect and maintain information about the child and the birth family, legal documents, and other information that will assist in fulfilling the responsibility of guardian.

"Life book" means a compilation of information about the child, including birth information, photographs of the child; placement history, including dates of placement, names of caretakers, and reasons for leaving the placement; relationships; school reports; social, medical, mental health developmental history; and awards received, important events, letters from significant persons, and other information that the child wishes to include. The life book will assist the child in dealing with separation and loss issues and provide background and genealogy data.

"Placement services" includes the activities and travel necessary to plan and carry out the placement of a child or children into the adoptive family.

"Postadoption services" includes those services that an adoptive family may access after the adoption is finalized to assist the family in coping with and resolving problems within the family.

"Postplacement services" includes the supervision, support and intervention necessary prior to finalization to assist in maintaining the adoptive placement.

"Preadoptive family" means an approved adoptive family with a child placed in the home for adoption whose adoption has not been finalized.

"Preparation of child" includes activities necessary to ready the child for placement into an adoptive family.

"Preparation of family" includes the activities necessary to assist the family in adding an adoptive child as a new member of their family.

"Preplacement visits" means contacts, activities, and visits between the child and adoptive family prior to the adoptive placement.

"Procedendo" means an order issued by the Iowa Supreme Court returning jurisdiction to the district court after a final appellate decision regarding an appeal.

"Recruitment and retention contractor" or *"contractor"* means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents, or any of its subcontractors.

"Relative" means an individual related to a child within the fourth degree of consanguinity or affinity, by marriage, or through adoption.

"Selection of family" means reviewing approved home studies to match a family's strengths with a specific child's needs.

[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.2(600) Application. Persons wishing to apply to adopt a child through the department shall complete an Application for Adoption form. An application for adoption shall only be accepted for children who are under the guardianship of the department.

200.2(1) *Limitations.* The department and its contractor shall accept only applications for adoption of a special needs child. The department shall refer adoption applications for children without special needs to private child-placing agencies. Exceptions to this rule may be made for:

a. Relatives of a child under the guardianship of the department; or

b. Foster parents with whom the child has a significant relationship.

200.2(2) *Procedures.* Before a home study is completed, applicants shall:

a. Complete the Application for Adoption form, and

b. Ensure that the Physician's Report for Foster and Adoptive Parents form is completed by the applicant's family physician.

[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.3(600) Adoption services. Adoption services shall include: adoptive home study, preparation of child, selection of family, preparation of family, preplacement visits, placement services, and postplacement services.

200.3(1) *Adoptive home study.* For applicants who apply to the department to adopt, the contractor shall prepare an adoptive home study through the following activities:

a. Family assessment. The family assessment shall include a minimum of two face-to-face interviews with the applicants and at least one face-to-face interview with each member of the household. At least one of the interviews shall take place at the applicant's home. The assessment of the prospective adoptive family shall include an evaluation of the family's ability to parent a special needs child or children including the following:

(1) Motivation for adoption and whether the family has biological children, adopted children or children in foster care currently placed in the home.

(2) Family's and extended family's attitude toward accepting an adopted child and plans for discussing adoption with the child.

(3) The attitude toward adoption of other people involved with the family in a significant way.

(4) Emotional maturity; marital history, including verification of marriages and divorces; assessment of marital relationship; and compatibility of the adoptive parents.

(5) Ability to cope with problems, stress, frustrations, crises, separation, and loss.

(6) Medical, mental, and emotional conditions that may affect the applicant's ability to parent a child; treatment history; status of treatment; and the evaluation of the treatment. Applicants and all household members must disclose any past or current mental health or substance abuse issues, or both. The department may require further documentation, evaluation, or both, to determine the suitability of the home.

(7) Willingness to accept a child who has medical problems (such as a child who is at risk for a communicable disease), intellectual disabilities, or emotional or behavioral problems. Ability to provide for the child's physical, medical, and emotional needs and commit to support a child's overall well-being.

(8) Description of biological children and previously adopted children, if any, including their attitudes toward adoption, relationship with others, and school performance.

(9) Capacity to give and receive affection.

(10) Statements from three references provided by the family and additional references the contractor may wish to contact.

(11) Attitudes of the adoptive applicants toward the birth parents and the reasons the child is available for adoption.

(12) Financial information, including the family's ability to provide for a child.

(13) Disciplinary practices that will be used.

(14) History of abuse involving family members, including how the abuse was addressed and how that history impacts the applicant's ability to be an adoptive parent.

(15) Assessment of, commitment to, and capacity to maintain other significant relationships.

(16) Recommendations for the number, age, sex, characteristics, and special needs of a child or children the family can best parent.

(17) The family's ability to anticipate and understand the special needs of an adopted child as the child gets older and how the family will manage those needs.

b. Record checks. Record checks are required for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether any of those persons have founded child abuse reports, dependent adult abuse reports or criminal convictions or have been placed on the sex offender registry.

(1) The records of the applicants shall be checked:

1. On the Iowa central abuse registry using the Request for Child Abuse Information form;

2. By the Iowa division of criminal investigation, using the HHS Criminal History Record Check Form B;

3. On the Iowa sex offender registry;

4. On the child abuse registry of any state where the applicant has lived during the five years prior to the issuance of the investigative report; and

5. For a national criminal history through fingerprinting or another biometric identification-based process accepted by the federal government.

(2) The records of persons aged 14 or older living in the home of the applicant shall be checked:

1. On the Iowa central abuse registry using the Request for Child Abuse Information form;

2. By the Iowa division of criminal investigation, using the HHS Criminal History Record Check Form B; and

3. On the Iowa sex offender registry.

(3) Out-of-state child abuse checks, dependent adult abuse checks and national criminal history checks may be completed on any adult living in the home of the applicant if the department has reason to do so.

(4) The department shall not approve a prospective applicant and shall not perform an evaluation if the applicant or anyone living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."*

(5) The department shall not approve a prospective applicant and shall not perform an evaluation if the applicant or anyone living in the home of the applicant has committed a crime in a state other than Iowa that would be a forcible felony if the crime would have been committed in Iowa, as set forth in Iowa Code section 600.8(2)*"b."*

c. Evaluation of record.

(1) If the applicant or anyone living in the home has a record of founded child abuse, dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the applicant shall not be approved to adopt unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

(2) The evaluation shall be conducted according to procedures in 441—subrules 113.13(2) and 113.13(3) for applications for adoption through the department or procedures in 441—paragraph 108.9(4)*"e"* for applications for adoption through a child-placing agency.

d. Written report. The contractor shall prepare a written report of the family assessment, known as the adoptive home study, which shall be used to make recommendations on appropriate placement.

(1) The department shall notify the family of the decision using the Adoption Notice of Decision form.

(2) If the department does not approve the home study, the reasons shall be stated on the notice.

(3) The department shall provide the family a copy of the adoptive home study with the notification of approval or denial.

e. Preplacement assessment and home study update. A preplacement assessment and home study update is required if the adoptive home study was written more than two years previously, in accordance with Iowa Code section 600.8. The preplacement assessment and home study update shall be conducted by completion of the following:

(1) The child abuse, dependent adult abuse and criminal record checks shall be repeated, except for fingerprinting. If there are any founded abuses or convictions of crimes that were not evaluated in the previous home study, they shall be evaluated using the process set forth in paragraph 200.4(1)*"c."*

(2) One face-to-face visit shall be conducted with the approved adoptive family.

(3) The information in the approved adoptive home study shall be reassessed.

(4) An updated written report of the reassessment and adoptive home study shall be written, dated, signed by the worker and supervisor for the contractor, and a copy provided to the adoptive family.

(5) Families that are dually licensed to provide foster family care shall have their adoption approval date align with their foster home licensing date.

f. Procedure for foster parent adoptions. When a licensed foster parent applies for approval as an adoptive home, home study activities that have been completed within the previous year as part of a licensing study pursuant to 441—Chapter 113 need not be repeated.

g. Annual visits to the adoptive family home. The contractor shall complete a minimum of one visit each year in the homes of families approved to adopt.

(1) The visit shall not be waived.

(2) When a person aged 14 or older moves into the home, the agency shall perform checks on the Iowa central abuse registry, by the division of criminal investigation, and on the sex offender registry. The

record check evaluation process shall be completed if the person has a criminal conviction or founded abuse report or is on the sex offender registry.

(3) Findings and observations of the visit shall be documented and provided to the department when the update is submitted.

(4) The department shall be notified within 30 days of any deficiencies noted or other concerns discovered that require corrective action.

200.3(2) *Preparation of child.* The department shall conduct specific activities designed to enable a child to make the transition to an adoptive placement or refer the child to the family-centered services contractor or other professionals. The activities shall include, but not be limited to:

a. Counseling regarding issues of separation, loss, grief, guilt, anger and adjustment to an adoptive family.

b. Assisting in the preparation or update of a life book.

c. Provision of age-appropriate information regarding community resources available, such as children's support groups, to assist the child in the transition and integration into the adoptive family.

d. Any appropriate evaluations or testing.

200.3(3) *Adoption selection process.* When the department is appointed guardian of a child(ren) following the termination of parental rights, the department has both the duty and the authority to select an adoptive placement for that child(ren). To fulfill this duty, the department must hold a conference during which the department selects an adoptive family for an identified child(ren). At the conference, known as an adoption selection staffing, each interested family with an approved adoption or interstate compact home study will be considered. The adoption selection committee will determine which family will be able to best meet the needs of the child(ren) going forward. The adoption selection process will value the best interest of the child(ren) above all else.

a. The selection committee will consider placement priority as outlined in Iowa Code section 232.117 and will consider the following:

(1) The adoptive family selected for a child or sibling group must be based on a thorough assessment of each child's current and potential developmental, medical, emotional, and educational needs.

(2) The child(ren)'s need for family connections will be prioritized. Separation of siblings should be avoided. When separation is necessary to protect the safety and well-being of one or more children in the sibling group, all reasonable efforts must be made to select a placement likely to maintain contact between siblings if such contact is in the best interests of each sibling.

(3) The adoptive family selected will be able to nurture and accept the child(ren) as a fully integrated member(s) of the family.

(4) Race, color, or national origin may not be considered in placement selections except when an Indian child is being placed pursuant to Iowa Code section 232.7 or chapter 232B.

(5) Placement decisions shall be made consistent with the best interests and special needs of the child, including the adoptive family's capacity and commitment to holistically supporting the child's development and well-being.

(6) A relative who is within the fourth degree of consanguinity shall be given consideration for selection as the adoptive family for a child who is legally available for adoption if the child has a significant relationship with the relative or the child is aged 14 or older and elects adoption by the relative.

(7) Foster parents shall be given consideration for selection as the adoptive family for a child in the foster parents' care who is legally available for adoption if the child has been in the foster parents' care for six months or longer or the child has a significant relationship with the family.

b. The adoption selection committee team should strive to complete the adoption selection process in 60 days or less absent special circumstances.

c. Upon reaching a decision, the adoption selection committee team staff will notify families of the decision made by the adoption selection committee team and will send placement notification to the family not selected within two business days of the date all parties were initially notified, using the Adoption Notice of Decision form.

d. The selection of an adoptive family is not an appealable issue since a child continues to be under the guardianship of the department until an adoption is finalized.

200.3(4) *Preparation of family.* The contractor and the department shall conduct activities designed to enhance the family's readiness to accept the child or children into the family and strengthen the family's commitment to adopt. A referral may be made for family-centered services if needed. The activities shall include, but not be limited to:

a. Completion of required preservice training and the self-study course, "Universal Precautions in Foster and Adoptive Family Homes," before placement of a child. These training requirements apply to families who are adopting special needs children who are under the guardianship of the department.

(1) Relatives who have cared for a related child for at least six months and who have been selected to adopt that related child may have their participation in the preservice training waived by the service area manager or designee.

(2) The department may waive the preservice training requirement in whole or in part when the department finds that:

1. The applicant has completed relevant training or has a combination of relevant training and experience that is an acceptable equivalent to all or a portion of the required preservice training; or

2. There is good cause for the waiver based upon the circumstances of the child and the applicant.

(3) Applicants must retake the preservice training if the adoption approval process is not completed within 24 months after the preservice training is initially completed.

b. Discussion with family members regarding problems resulting from a child's separation, loss, grief, and anger due to the loss of the birth parents.

c. Provision of background information on the child and birth family, including a child study that includes experiences such as foster and adoption placements and other pertinent information and the child's life book.

d. Provision of information regarding the child's special needs and behavior patterns.

e. Provision of a description of the child's medical needs, including whether or not the child has a communicable disease.

f. Discussion of the impact that adding a new member or members to the family may have on all current family members.

g. Explanation of the state's subsidized adoption program.

h. Provision of information regarding the community resources that are available to assist the family, such as parent support groups, community supports including Medicaid funded supports and post adoption supports.

200.3(5) *Preplacement visits.* The department shall plan, conduct and assess the transitional visits between the adoptive family and the child or children before the adoptive placement of the child in the home.

200.3(6) *Placement services.* Placement services include the activities necessary to plan and carry out the placement of a child or children into the adoptive family.

Before placement of a child, the Agreement of Placement for Adoption form shall be signed by all parties.

200.3(7) *Postplacement services.* An adoptive family is eligible for postplacement services from the time a child is placed with the family until finalization of the adoption occurs. The department shall supervise the placement, provide ongoing support to the child and family, perform crisis intervention, and complete required reports. Assistance with behavioral interventions to strengthen the placement and prevent disruption may be provided through family-centered services.

a. Postplacement supervision shall focus on the following areas:

(1) Integration and interaction of the child or children with the family.

(2) Changes in the family functioning that may be due to the child's placement.

(3) Social and emotional adjustment of the child or children.

(4) Child's growth and development since placement with the adoptive family.

(5) Changes and adjustments that have been made in the family since the child's placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

(8) School adjustment of a child who is attending a school.
(9) The behavioral needs of the child.
(10) The psychological and mental health needs of the child.
(11) Services and supports that will assist the child and family in the future.

b. At a minimum, the department shall make monthly home visits until the adoption is final. If the family is experiencing problems, the department shall make as many visits as are necessary to assess and support the placement.

c. The department shall prepare a written report based on the postplacement visits with recommendations regarding the finalization of the adoption and submit the report to the court before the hearing to consider granting a decree of adoption.

200.3(8) *Postadoption services.* The department's contractor shall provide postadoption services to families that are eligible for the department's adoption subsidy program in accordance with the contract. The goal of these services is to prevent adoption dissolution. The family may obtain additional support through community resources or support groups.
[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.4(600) Termination of parental rights. The department shall not place a child in an approved adoptive home until parental rights of the child's birth parents have been terminated and guardianship assigned to the department. This would not apply to families and children participating in tribal customary adoption. If one or both birth parents are deceased, the worker shall provide the court with verification of the birth parents' death and the death shall be stated in the guardianship order. When the termination of parental rights is appealed by a birth parent, an adoptive placement may be made if the adoptive parents sign an adoptive placement agreement that includes an acknowledgment of the conditions of the placement should termination be overturned. However, the adoption may not be finalized until the appeal is withdrawn or a final decision regarding the appeal is reached and a procedendo issued.
[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.5(600) Interstate placements. Interstate placement of a child into Iowa, or out of Iowa, shall follow interstate placement of child procedures in accordance with Iowa Code sections 232.158 through 232.166.
[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.6(600) Requests for home studies.

200.6(1) *Court-ordered.* Court-ordered home studies for adoption of a child or children under the authority of the department shall be completed by the department's contractor.

200.6(2) *Interstate compact.* Requests for an adoptive home study through the interstate compact process shall be completed by the department's contractor.
[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.7(600) Reasons for denial.

200.7(1) An individual or family shall be denied approval of an adoptive home study for any of the following reasons unless an evaluation determines that denial is improper:

a. Founded child abuse report or dependent adult abuse report.
b. Criminal conviction.
c. Documented concerns. Concerns may be documented in one or more of the following areas:
(1) Motivation to adopt.
(2) Child-rearing ability and practices.
(3) Emotional stability.
(4) Physical or mental health.
(5) Interpersonal relationships.
(6) Finances.
(7) Marital relationship.
(8) Other areas that may impact the applicant's ability to meet the needs of a child both at present and in the future.

d. Substance abuse. Verified substance use or abuse that prevents the family from adequately caring for the child shall mean denial of approval.

e. Lack of cooperation. If the individual or family fails to cooperate in providing the information needed to complete the preplacement assessment or home study, the application shall be denied.

200.7(2) Prospective adoptive families may appeal denial of approval of their home study.

[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.8(600) Removal of child from preadoptive family. When the department determines that it is in the child's best interest to be removed from a preadoptive family, a Letter of Removal form shall be mailed to the family prior to removal. Removal of a child from a preadoptive family is not an appealable action.

[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.9(600) Consents.

200.9(1) A request for consent to the adoption shall be submitted to the guardian for a child who is under the guardianship of the department and for whom finalizing an adoption is recommended. If the adoption is in the best interest of the child, the department shall sign a Consent to Adoption form, prior to a court hearing finalizing the adoption.

200.9(2) A consent to adopt may be rescinded by the department, by signing a Rescinding the Consent to Adoption form for any of the following reasons:

a. At the request of the adoptive family.

b. A founded child abuse report, dependent adult abuse report, accusation of child abuse, or dependent adult abuse pending determination of the report.

c. Conviction of a crime, or accusation of a crime, pending a court decision regarding the crime.

d. At the request of a child who is aged 14 or over and has reversed the decision regarding the adoption.

e. Other verified indications that the adoption is not in the best interest of the child.

[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.10(600) Requests for access to information for research or treatment.

200.10(1) *Requests.* Any person seeking access to the department's sealed adoption records for the purpose or purposes set forth in Iowa Code section 600.16(1)*"c"* or 600.24(2) shall submit a request in writing to the department. Each request shall contain sufficient facts to establish that the information sought is necessary for conducting a legitimate medical research project, or for treating a patient in a medical facility.

200.10(2) *Process.* Upon receipt of a request for information sought in conducting a research project, the director or a designee shall review the request for information and make a decision to approve or deny the request based on the research to be conducted, the benefits of the research, the methodology, and the confidentiality measures to be followed. Upon a request for information for treating a patient in a medical facility, a decision regarding approval or denial shall be made by the director or designee based on the written information provided by a physician or the medical facility making the request. A requester shall be notified in writing of approval or denial and, if denied, reasons for denial given.

[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

441—200.11(600) Requests for information for purposes other than research or treatment. Requests for information from department adoption records for purposes other than research or treatment shall be made on the department's website.

200.11(1) The department shall not release identifying information from sealed adoption records. Adult adoptees, adoptive parents, birth parents, siblings or descendants of an adopted person, or legal representatives of any of the above, shall be provided:

a. An adoption packet containing a sample affidavit for filing with the court,

b. Directions for filing the affidavit,

c. A list of county clerks of court,

d. The address of the bureau of vital statistics, and

e. Instructions on how to obtain the name of the Iowa county where the adoption was finalized, if necessary.

200.11(2) An adopted person who was a resident of the Annie Wittenmyer Home may receive nonidentifying information from Annie Wittenmyer records if the information is available.

[**ARC 8110C**, IAB 7/10/24, effective 8/14/24]

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CHAPTER 201
SUBSIDIZED ADOPTIONS

[Prior to 7/1/83, Social Services(770), Ch 138]
[Previously appeared as Ch 138—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services(498)]

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

441—201.1(600) Administration. The department shall administer the subsidized adoption program, in conformance with the legal requirements for adoption.
[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.2(600) Definitions.

"Child" means a person who has not attained age 18 or a person with a physical or mental disability who has not attained age 21.

"Escrow account" means an interest-bearing account in a bank or savings and loan association that is maintained by the department in the name of a particular child.

"Maintenance subsidy" means a monthly payment to assist the family in meeting the living expenses and expenses related to the care of a child with special needs in covering the cost of room, board, clothing, and spending money. The child will also be eligible for medical assistance pursuant to 441—Chapter 75.

"Nonrecurring expenses" means reasonable and necessary adoption fees, court costs, attorney fees and other expenses that are directly related to the legal adoption of a child with special needs. These shall be limited to attorney fees, court filing fees and other court costs.

"Physician" means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

"Presubsidy" means payment for maintenance or special services for a child with special needs who is placed in an adoptive home and who meets all eligibility criteria for maintenance subsidy but whose adoption is not finalized.

"Qualified intellectual disability professional" means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. A person who holds at least a bachelor's degree in a human services field, including but not limited to social work, sociology, special education, rehabilitation counseling, or psychology.

"Qualified mental health professional" means a person who meets all the following conditions:

1. Holds a master's degree in a mental health field, including but not limited to psychology, counseling and guidance, psychiatric nursing, or social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws for persons practicing as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker; and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and services needs and in providing mental health services.

"Special services subsidy" means payment to a provider or reimbursement to the parent for medical, dental, therapeutic, or other services, equipment or appliances required by a child to meet the child's identified special needs.
[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.3(600) Conditions of eligibility or ineligibility.

201.3(1) The child is eligible for subsidy when the department or a private agency has documented that it has been unable to place the child in an appropriate adoptive home without a subsidy and the child is determined to be a child with special needs based on one or more of the following reasons:

a. The child has a medically diagnosed disability, as determined by a physician, an advanced registered nurse practitioner or a physician associate, that substantially limits one or more major life activities, requires ongoing professional treatment, impacts the child's ability to perform daily living skills, and is expected to last 12 months or longer.

b. The child has been determined by a qualified intellectual disability professional to be intellectually disabled.

c. The child has been determined by a qualified professional to be at high risk of developing a qualifying medical, mental, or emotional condition as defined in this subrule. A child in this group is eligible for subsidy of nonrecurring expenses only.

d. The child has been diagnosed by a qualified mental health professional to have a psychiatric condition that impairs the child's mental, intellectual, or social functioning and for which the child requires ongoing professional services.

e. The child has been diagnosed by a qualified mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior that deviates substantially from behavior appropriate to the child's age or significantly interferes with the child's intellectual, social and personal adjustment and that requires ongoing treatment.

f. The child is aged five or older.

g. The child is a member of a sibling group of three or more children who are placed in the same adoptive home.

201.3(2) A child who enters the United States from another country on the basis of a visa classifying the child as an orphan, in accordance with the Immigration and Naturalization Act as amended to December 31, 2023, for the purpose of adoption by a specific United States family is not eligible for subsidized adoption maintenance payments, medical assistance, or special services, except for nonrecurring expenses.

201.3(3) Adverse eligibility determinations by the department may be appealed according to rules in 441—Chapter 2506.

201.3(4) The department shall review the subsidy agreement when the child reaches the age of 17½ to determine whether the child is eligible to receive subsidy to the age of 21 due to the child's physical, intellectual, or mental health disability.

a. The disability shall be diagnosed by a physician, a qualified mental health professional, or a qualified intellectual disability professional.

b. The diagnosis shall be current within one year prior to the child's eighteenth birthday.

c. The child's parents shall provide documentation of the child's disability.

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25; Editorial change: IAC Supplement 6/10/26]

441—201.4(600) Application. Application for presubsidy or subsidy for a child with special needs in the guardianship of the department shall be made at the time of the adoptive placement of the child, or at any time in the adoptive process before finalization of the adoption.

201.4(1) The prospective adoptive family residing in Iowa who has been studied and approved for adoptive placement, or a family residing outside of the state of Iowa studied and approved by a governmental child-placing agency or a licensed child-placing agency in that state, may apply for subsidy for an eligible Iowa child.

201.4(2) Withdrawal of the subsidy application shall be reported to the department immediately.

201.4(3) The effective date for the Adoption Subsidy Agreement will be the date the agreement is signed by the adoptive parents and the department, which may be the date the child is placed in the adoptive home or any date up to and including the date the adoption is finalized. The agreement shall state the amount of the presubsidy or subsidy, the frequency and duration of payments and the conditions under which the agreement may be terminated.

201.4(4) An application for subsidy cannot be taken after the child is adopted except when there are facts relevant to a child's eligibility that were not presented before the finalizing of the adoption.

a. Upon receiving verification that the child was eligible before the child's adoption, the department may conduct an administrative review of the facts and may determine that the child is an eligible child with

special needs. Eligibility will be effective after the Application for Subsidy is completed and the Adoption Subsidy Agreement form is signed by all parties.

b. Requests for determination after the adoption is finalized shall be forwarded with verification of eligibility to the department. The department shall conduct an administrative review of eligibility factors and render a written decision within 30 days of receipt of request and verification materials unless additional verification is requested. If additional verification is requested, a decision shall be reached within 30 days of receipt of additional verification materials.

201.4(5) A child in the guardianship of a licensed child-placing agency may be eligible for adoption subsidy when one of the following conditions is met:

a. The child receives or is eligible to receive SSI based on a diagnosed disability, or

b. The child received federally funded adoption subsidy in a prior adoption.

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.5(600) Negotiation of amount of presubsidy or subsidy.

201.5(1) The amount of presubsidy or subsidy shall be negotiated between the department and the adoptive parents and shall be based upon the needs of the child and the circumstances of the family.

a. Each time negotiations are completed, the Adoption Subsidy Agreement shall be completed.

b. The Adoption Subsidy Agreement shall be completed and retained in an inactive case record for future reference when:

(1) A child is eligible for subsidy but the child or family does not currently need assistance; or

(2) The child is at risk of being determined a child with special needs according to paragraph 201.3(1) *"a," "b," "d,"* or *"e"* in the future.

201.5(2) Other services available to the family free of charge to meet the needs of the child, such as other federal, state, and local governmental and private assistance programs, shall be explored and used before the expenditure of subsidy funds.

Unearned income of the child shall be verified by documentation provided to the department worker by the family from the source of the income.

201.5(3) A maintenance subsidy may be no less than $10 per month.

201.5(4) An adoptive family may request a review of the subsidy agreement when there is a change in the family's circumstances or the needs of the child.

201.5(5) Maintenance subsidy shall continue under the same rules if the adoptive family moves outside of the state of Iowa.

201.5(6) The maximum monthly maintenance payment for a child in subsidized adoption shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found at rule 441—156.6(234).

a. The maximum monthly maintenance payment for a child in subsidized adoption shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found in 441—subrule 156.6(1) and 441—paragraph 156.6(4)*"f"* for eligible adoptions that take place on or after July 1, 2025. Eligible subsidized and future subsidized adoptions that took place on June 30, 2025, or before will remain on the basic rate in effect on June 30, 2025.

b. Basic rate effective July 1, 2025:

Age of child	Daily rate
0 through 5	$18.50
6 through 11	$19.24
12 through 15	$21.06
16 or older	$21.34

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25; **ARC 9860C**, IAB 12/24/25, effective 2/1/26]

441—201.6(600) Types of subsidy.

201.6(1) *Special services only.*

a. Reimbursement to the family or direct payment to a provider may be made for the following special services needed to meet the needs of the child:

(1) Outpatient counseling or therapy services. Reimbursement for outpatient individual or family services may be provided from a non-Medicaid provider only with approval from the department and when one of the following applies:

1. The services are not available from a Medicaid provider within a reasonable distance from the family.

2. The child and the family were already receiving therapy or counseling from a non-Medicaid provider and it would not be in the child's best interest to disrupt the services.

3. Available Medicaid providers lack experience in working with foster, adoptive, or blended families.

Reimbursement to non-Medicaid providers shall be limited to the Medicaid rate.

(2) Expenses for transportation, lodging, or per diem related to preplacement visits, not to exceed $2,000 per family.

(3) Medical services not covered by the Medicaid program when the child, either alone or with the family, resides outside the state of Iowa and that state's Medicaid does not cover a needed service, or a provider enrolled with Iowa Medicaid cannot be secured. An adoption subsidy payment shall not supplement the Medicaid payment rate to a Medicaid provider or a non-Medicaid provider.

(4) An additional premium amount as a result of adding the child to the family's health insurance group.

(5) Medical transportation, food and lodging not covered by Medicaid when the child is receiving specialized care in a facility 50 miles or farther from the family home, when the family is participating in services and to facilitate reunification with the child.

(6) Supplies and equipment as required by the child's special needs and unavailable through other resources.

1. When the siblings in a sibling group of three or more are placed together, a one-time-only payment can be made, not to exceed $500 per child, to reimburse the family for expenses related to accommodating the needs of the sibling group.

2. When home modifications have been authorized to accommodate a child's special needs and the family later sells the house, the family shall repay the department an amount equal to the increase in the equity value of the home attributable to the modifications.

(7) Nonrecurring expenses. Payment for nonrecurring expenses is generally limited to a total of $1,000 per child for attorney fees, court costs and other related legal expenses. Nonrecurring expenses may be paid when the adoptive family has negotiated an Adoption Subsidy Agreement or an Agreement to Future Adoption Subsidy.

(8) Funeral benefits at the amount allowed for a foster child in accordance with 441—Chapter 156.

b. The need for special services shall be documented in the Adoption Subsidy Agreement. The family shall provide documentation of expenses to the department.

c. Any single special service and any special service delivered over a 12-month period costing $500 or more shall have prior approval from the central office adoption program manager prior to expending program funds.

d. For all Medicaid covered services, the department shall reimburse at the same rate and duration as Medicaid as set forth in rule 441—79.1(249A).

201.6(2) *Maintenance only.* A monthly payment to assist with room, board, clothing and spending money may be provided, as determined under this chapter. The child will also be eligible for medical assistance pursuant to 441—Chapter 75.

201.6(3) *Maintenance and special services.* For children with special needs, a special services subsidy may also be included when a maintenance subsidy is provided.

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.7(600) Determination of ongoing subsidy eligibility and suspension of subsidy payments.

201.7(1) Eligibility for continuation of adoption subsidy shall be evaluated when the department has reasonable cause to suspect the adoptive parent is not providing financial support or is no longer legally responsible for the child. This includes but is not limited to the following circumstances:

a. The child is placed in out-of-home care.

b. A person alleges the parents are not providing financial support to the child.

c. A person other than the parent is awarded legal custody of the child.

d. A person other than the parent is appointed as the guardian of the child.

e. The child has applied for food assistance or other benefits.

f. The child has not resided with the parent for the past 30 consecutive days.

g. The parent is incarcerated.

h. The parent is awaiting trial for criminal charges related to harm caused to a child in the home.

201.7(2) The department will contact the child's parents via letter, telephone, or electronic or other means and document such efforts.

201.7(3) The child's parents shall provide documentation of support, including receipts, to the department upon request.

201.7(4) Upon completion of the department's evaluation of the child's continued eligibility for adoption subsidy, the department will issue a written notice to the parents documenting required ongoing actions by the parents, including an expectation of continued cooperation by the parents to provide documentation of ongoing support to the child at the request of the department.

201.7(5) The department shall suspend adoption subsidy payments if the parents refuse to cooperate or if the department is unable to determine whether the parents are providing financial support or are legally responsible for the child.

201.7(6) Through a Notice of Decision, the department shall terminate the Adoption Subsidy Agreement upon a finding that the child is not being financially supported.

201.7(7) When the child has resided out of the parental home for 30 consecutive days, the department will request a renegotiation of the Adoption Subsidy Agreement with the parents to reduce or suspend payments as agreed to by the parents.

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.8(600) Termination of subsidy. Subsidy will terminate when any of the following occur:

201.8(1) The adoptive child no longer meets the definition of child in rule 441—201.1(600).

201.8(2) The child marries.

201.8(3) The adoptive parents are no longer using the maintenance payments to support the child.

201.8(4) Death of the child or death of the parents of the child (one in a single-parent family and both in a two-parent family).

201.8(5) Upon conclusion of the terms of the agreement.

201.8(6) Upon request of the adoptive parents.

201.8(7) The adoptive parents are no longer legally responsible for the child.

201.8(8) The child enlists in the military.

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.9(600) Reinstatement of subsidy. Reinstatement of subsidy will be made when the subsidy was terminated because of reasons in subrule 201.8(3), 201.8(6), or 201.8(7) and the reason for termination no longer exists.

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.10(600) New application. New applications will be taken at any time, but processed only so long as funds are available. Maintenance and special services already approved will continue.

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.11(600) Medical assistance based on residency. Children with special needs eligible for any type of subsidy are entitled to medical assistance as defined in 441—Chapter 75. The funding source for medical assistance is based on the following criteria:

201.11(1) IV-E-eligible children:

a. IV-E-eligible children residing in Iowa from Iowa and from other states shall receive medical assistance from Iowa.

b. IV-E-eligible children from Iowa residing in another state shall receive medical assistance from the family's state of residence, even though medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

201.11(2) Non-IV-E-eligible children:

a. Non-IV-E-eligible children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

b. Non-IV-E-eligible children from Iowa residing in another state shall be covered by Iowa's medical assistance unless eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act as amended to December 31, 2023.

c. Non-IV-E-eligible children from another state residing in Iowa shall be covered by Iowa's medical assistance if all the following conditions are met:

(1) The child is under the age of 21.

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

(3) Another state is currently paying an adoption subsidy for the child pursuant to an adoption assistance agreement in effect for the child with that state.

(4) The state paying the adoption subsidy is a member of the interstate compact on adoption and medical assistance (ICAMA).

(5) The state paying the adoption subsidy provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act as amended to December 31, 2023, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

201.11(3) When an Iowa child receives medical assistance from another state, Iowa shall discontinue paying any medical costs the month following the move unless additional time is necessary for a timely notice of decision to be provided to the family. An exception shall be made when the initial Iowa subsidy agreement provides for services not covered by the other states.

[**ARC 8415C**, IAB 11/27/24, effective 1/1/25]

441—201.12(600) Presubsidy recovery. The department will recover the cost of presubsidy maintenance and special services provided by the department as follows:

201.12(1) Funds will be applied to the cost of presubsidy maintenance and special services from the unearned income of the child.

201.12(2) The department will serve as payee to receive the child's unearned income. The income will be placed in an account and be applied toward the cost of the child's current care with the remainder placed in an escrow account.

201.12(3) When a child has funds in escrow, these funds may be used by the department to meet the current needs of the child not covered by the presubsidy payments and not prohibited by the source of the funds.

201.12(4) When the child leaves presubsidy care, funds in the escrow shall be paid to the adoptive parents or to the child if the child has attained the age of majority.

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CHAPTER 202
FOSTER CARE PLACEMENT AND SERVICES

[Prior to 7/1/83, Social Services[770] Ch 136]
[Previously appeared as Ch 136—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

441—202.1(234) Definitions.

"Age- or developmentally appropriate activities" means activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

"Case permanency plan" means the plan identifying goals, needs, strengths, problems, services, time frames for meeting goals and for delivery of the services to the child and parents, objectives, desired outcomes, and responsibilities of all parties involved and reviewing progress. This includes information describing efforts to retain existing medical and mental health care providers for a child entering or in foster care and activities to evaluate service needs to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities.

"Child" means the same as defined in Iowa Code section 234.1.

"Department" means the Iowa department of health and human services and includes the local offices of the department.

"Eligible child" means a child for whom the court has given guardianship to the department or has transferred legal custody to the department or for whom the department has agreed to provide foster care services on the basis of a signed placement agreement or who has been placed in emergency care for a period of not more than 30 days upon the approval of the director or the director's designee.

"Facility" means the personnel, program, plant and equipment of a person or agency providing child foster care.

"Family-centered services" means the same as defined in 441—Chapter 172.

"Fictive kin" means the same as defined in 441—Chapter 172.

"Foster care" means the same as defined in Iowa Code section 237.1(3).

"Kinship caregiver" means a relative or fictive kin who is caring for a child in foster care, under court-ordered supervision pursuant to Iowa Code chapter 232.

"Person" or *"agency"* means individuals, institutions, partnerships, voluntary associations, and corporations, other than institutions under the management or control of the department, who are licensed by the department as a foster family home, child caring agency or child placing agency, or approved as a shelter care facility.

"Reasonable and prudent parent standard" means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encourage the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, and social activities. For the purposes of this definition, "caregiver" means a foster parent with whom a child in foster care has been placed or a designated official for a child care institution (including group homes, residential treatment, shelters, or other congregate care settings) in which a child in foster care has been placed.

"Relative" means an individual related to a child within the fourth degree of consanguinity or affinity, by marriage, or through adoption.

"Resource family" means an individual person or married couple who is licensed to provide foster family care or approved for adoption.

"Safety-related information" means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

"Service area manager" means the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Social history" or *"child study"* means a written description of the child that includes strengths and needs; medical, mental, social, educational, placement and court history; and the child's relationships with the birth family and significant others.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 5249C**, IAB 11/4/20, effective 1/1/21; **ARC 5540C**, IAB 4/7/21, effective 7/1/21; **ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.2(234) Eligibility.

202.2(1) Only an eligible child as defined in these rules shall be considered for foster care services supervised by the department.

202.2(2) The need for foster care placement and social and other related services, including but not limited to medical, psychiatric, psychological, and educational services, shall be determined by an assessment of the child and family to determine their needs and the appropriateness of services.

a. Assessments shall include:

(1) The educational, physical, psychological, social, family living, and recreational needs of the child,

(2) The family's ability to meet those needs, and

(3) A family genogram to determine relatives and other suitable support persons who have a kinship bond with the child.

b. The assessment is a continual process to identify needed changes in service or placement for the child.

202.2(3) With the exception of emergency care, a social history shall be completed on each child before a department recommendation for foster care placement, using the outline RC-0027, Social History Format.

a. For voluntary emergency placements, a social history shall be completed before a decision is made to extend the placement beyond 30 days.

b. For court-ordered emergency placements, a social history shall be completed before the disposition hearing.

202.2(4) Foster care placement shall be recommended by the department only after efforts have been made to prevent or eliminate the need for removal of the child from the family unless the child is in immediate danger at home.

202.2(5) The need for foster care and the efforts to prevent placement shall be evaluated by a review committee prior to placement or, for emergency placements only, within 30 days after the date of placement. For children who are mentally retarded or developmentally disabled and receive case management services, this requirement may be met by the interdisciplinary staffing described in 441—Chapter 90, as long as the service area manager approves, the department worker attends the staffing, and the staffing meets the requirements of paragraphs *"b"* to *"h"* below.

The review shall meet the following requirements:

a. Department staff on the review committee shall be the child's service worker, a supervisor knowledgeable in child welfare, and one or more additional persons appointed by the service area manager.

b. The review shall be open to the participation of the parents or guardian of the child, local and area education staff, juvenile court staff, the guardian ad litem, current service providers and previous service providers who have maintained a license.

c. The present foster care provider, if any, shall be notified of the review and have the opportunity to participate.

d. Written notice of the review shall be sent to the child's parents or guardian at least five working days prior to the date of the review.

e. Other persons may be invited to the review with the consent of the parents or guardian.

f. A written summary of the review recommendations shall be sent to the child's parents or guardian following the review.

g. Review committee recommendations shall be advisory to the service worker and supervisor, who are responsible for development of the department case plan and for reports and recommendations to the juvenile court.

h. At least one of the persons on the review committee shall be someone without responsibility for the case management or the delivery of services to either the child or the parents or guardian who are the subject of the review.

202.2(6) The citizenship or alien status of a child who enters foster care must be verified.

a. When the child will remain in foster care for no more than 60 days, Form 470-4500, Statement of Citizenship Status: Foster Care, signed by the parent or guardian of the child is sufficient.

b. When the child will remain in foster care for more than 60 days, one of the documents listed in this paragraph is required. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A certificate of birth in the United States.

(2) Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

(3) Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

(4) A United States passport.

(5) Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

(6) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(7) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(8) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(9) Another document that provides proof of United States citizenship or nationality as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v) or 1396b(x)(3)(C)(v).

c. A child entering foster care is exempt from these requirements when the family has previously presented satisfactory documentary evidence of citizenship, as specified by the Secretary of the U.S. Department of Health and Human Services.

d. The parent or guardian of the child shall have a reasonable period to obtain and provide proof of citizenship. For the purposes of this requirement, the "reasonable period" begins on the date when the child is placed in foster care and continues to the date when the proof is provided or when the department establishes that the parent or guardian is no longer making a good-faith effort to obtain the proof.

This rule is intended to implement Iowa Code sections 234.6(1) and 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.3(234) Voluntary placements.

202.3(1) All voluntary placement agreements initiated after July 1, 2003, for children under the age of 18 shall terminate after 90 days.

202.3(2) When the voluntary placement is of a child who is under the age of 18, a Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the parent(s) or guardian and the county office where the parent or guardian resides. Voluntary Foster Care Placement Agreements shall not be used to place children outside Iowa and shall not be signed with parents or guardians who

reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's parent or guardian moves outside Iowa after the placement.

202.3(3) Voluntary placement of a child aged 18 or older may be granted for six months at a time.

a. The department shall enter into the agreement only when the child:

(1) Meets the definition of "child" in Iowa Code section 234.1,

(2) Was in foster care or a state institution immediately before reaching the age of 18,

(3) Has continued in foster care or a state institution since reaching the age of 18,

(4) Has demonstrated a willingness to participate in case planning and to fulfill responsibilities as defined in the case permanency plan, and

(5) Will be placed in foster family care or supervised apartment living in Iowa.

b. Payment shall be limited pursuant to 441—paragraph 156.20(1)*"b."*

c. When the voluntary placement is of a child who is aged 18 or older and who has a court-ordered guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the guardian and the local office where the guardian resides. Voluntary Foster Care Placement Agreements shall not be signed with guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's guardian moves outside Iowa after the placement.

d. When the voluntary placement is of a child who is aged 18 or older and who does not have a court-appointed guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the child and the local office where the child resides.

e. An exception to the requirement for continuous placement may be made for a youth who leaves foster care at age 18 and voluntarily returns to supervised apartment living foster care before the youth's twentieth birthday in order to complete high school or obtain a general equivalency diploma (GED).

202.3(4) All voluntary placements shall be approved by the service area manager or designee.

This rule is intended to implement Iowa Code sections 234.6(6)*"b"* and 234.35(1)*"c."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.4(234) Selection of facility.

202.4(1) Placement consistent with the best interests and special needs of the child shall be made in the least restrictive, most family-like facility available and in close proximity to the child's home. Race, color, or national origin may not be routinely considered in placement selections.

202.4(2) Efforts shall be made to place siblings together unless to do so would be detrimental to any of the children's physical, emotional or mental well-being. Efforts to prevent separating siblings, reasons for separating siblings, and plans to maintain sibling contact shall be documented in the child's case permanency plan.

202.4(3) The department shall first consider placing the child in a relative's home unless no relatives are available or willing to accept placement or such placement would be detrimental to the child's physical, emotional or mental well-being.

a. If a relative or a suitable person who has a kinship bond with the child will accept placement of the child:

(1) The person shall sign Form 595-1489, Non-Law Enforcement Record Check Request.

(2) The department shall complete record checks as listed in 441—subrule 113.13(1) to evaluate if the person's home is appropriate for the child before making the placement.

(3) The department worker shall make a referral to the recruitment and retention provider to initiate an informational contact with the kinship caregiver. The recruitment and retention provider will inform the kinship caregiver about the monthly kinship caregiver payment as outlined in rule 441—156.6(234) and explain the process of becoming a licensed foster parent.

b. Efforts to place the child in a relative's home and reasons for using a nonrelative placement shall be documented in the child's case permanency plan.

202.4(4) Foster family care shall be used for a child unless the child has problems that require specialized services that cannot be provided in a family setting. Reasons for using a more restrictive placement shall be documented in the child's case permanency plan.

202.4(5) A foster family shall be selected on the basis of compatibility with the child, taking into consideration:

a. The extent to which interests, strengths, abilities and needs of the foster family enable the foster family members to understand, accept and provide for the individual needs of the child.

b. The child's individual problems, medical needs, and plans for future care. The department shall not place a child with asthma or other respiratory health issues in a foster home where any member of the household smokes.

c. The capacity of the foster family to understand and accept the child's case permanency plan, the needs and attitudes of the child's parents, and the relationship of the child to the parents.

d. The characteristics of the foster family that offer a positive experience for the child who has specific problems as a consequence of past relationships.

e. An environment that will cause minimum disruption of the child including few changes in placement for the child.

202.4(6) A foster group care facility shall be selected on the basis of its ability to meet the needs of the child, promote the child's growth and development, and ensure physical, intellectual and emotional progress during the stay in the facility. The department shall place a child only in a licensed or approved facility which has a current contract with the department pursuant to 441—Chapter 152.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 5540C**, IAB 4/7/21, effective 7/1/21; **ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.5(234) Preplacement.

202.5(1) Except for placements made in less than 24 hours, a child placed in a facility shall have a preplacement visit involving:

a. The child,

b. The foster parents or agency staff, if the child is placed in a public or private agency,

c. The department service worker, and

d. The child's parents, unless their presence would be disruptive to the child's placement.

202.5(2) Before placement, the department shall provide the facility with general information regarding the child, including a description of the child's medical needs, behavioral patterns including safety-related information, educational plans, and permanency goal. The department or the department's agent may share otherwise confidential information about a child with a licensed resource parent being considered as a possible placement for the child to the extent such disclosure is relevant to the placement decision and the proper care of the child. This may also include facilitating the sharing of contact information of the previous licensed resource parent with the potential licensed resource parent in an effort to support the continuity of care for a child. Safety-related information shall be withheld only if:

a. Withholding the information is ordered by the court; or

b. The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living or pose a risk to the safety of the licensed resource parent.

202.5(3) The child shall have a physical examination by a physician, advanced registered nurse practitioner, or a physician assistant before the initial placement into foster care, or the physical examination shall be scheduled within 14 calendar days of placement. The physician, advanced registered nurse practitioner, or a physician assistant shall complete a preliminary screening for dental and mental health and refer the child to a dentist or mental health professional if appropriate. To address any immediate medical needs, the child shall be seen immediately at an emergency room, an urgent care center, or other community health resource.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17; **ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.6(234) Placement.

202.6(1) At the time of placement, the department worker shall furnish to the foster care provider any available information regarding the child.

a. The information provided shall include:

(1) The child's full name and date of birth;

(2) The names, work addresses, and telephone numbers of the placement worker and the worker's supervisor, including a home telephone, cell phone, or on-call number;

(3) The names, addresses, and telephone numbers of the child's physician and dentist;

(4) The names, addresses, and telephone numbers of significant relatives of the child, including parents, grandparents, brothers and sisters, aunts and uncles, and any other significant persons (for an adopted child, the adoptive parents and adoptive relatives);

(5) The case permanency plan;

(6) The results of a physical examination, including immunization history;

(7) The child's medical needs including allergies, physical limitations, dental and medical recommendations, and special needs of HIV;

(8) Behavioral patterns including safety-related information;

(9) Educational arrangements including, but not limited to, the school the child attends, special education needs, and school contacts;

(10) The placement contract or agreement including the date of acceptance for care;

(11) Medical authorizations, service authorizations, and other releases as needed; and

(12) If the child is a Native American, the identification of the child's tribe and tribal social service agency, including telephone number and contact person.

b. Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information.

(1) The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

(2) Form 470-3226, HIV General Agreement, shall be completed by foster parents who have agreed to care for children who have AIDS, test HIV positive, or are at risk for HIV infection.

c. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

202.6(2) For each foster care placement in a foster family home supervised directly by department staff, Form 470-0716 or 470-0716(S), Foster Family Placement Contract, shall be completed by the foster family and the placement worker and supervisor. A new foster family placement contract shall be completed when the rate of payment or special provisions change.

202.6(3) A follow-up visit shall be made to the child at the foster family home within two weeks of the initial placement for placements supervised directly by the department.

202.6(4) The case permanency plan shall be reviewed at least every six months to ensure appropriateness of the child's placement. A copy of the subsequent case plan shall be submitted to the court every six months unless the court orders a different frequency for reports.

202.6(5) In conjunction with the case plan review, the case shall be presented every six months to a review committee that conforms to the requirements in subrule 202.2(5). The service area manager may also approve a review by a local foster care review board authorized in Iowa Code section 237.19 or the court as meeting this requirement as long as the review conforms to paragraphs 202.2(5)*"b"* to *"h"* and 202.6(5)*"a"* to *"e."* The review committee shall:

a. Evaluate the continuing necessity for foster care placement.

b. Evaluate the continuing appropriateness of the foster care placement.

c. Evaluate the extent of compliance with the case plan.

d. Evaluate the extent of progress made toward lessening the causes for foster care placement.

e. Project a likely date by which the child will leave foster care.

This rule is intended to implement Iowa Code sections 234.6(6)*"b"* and 237.19.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.7(234) Out-of-area placements.

202.7(1) When the department makes a placement of a child in the foster care system out of the service area in which the child resides, this placement shall occur only when there is no appropriate placement within the service area, when the placement is necessary to facilitate reunification of the child with the parents, or when an out-of-area agency is closer to the community where the child resides than an in-area agency offering the same services.

202.7(2) The authority for approving out-of-area placements rests with both the placing and receiving service area managers.

202.7(3) Transfer of responsibility for supervision, planning, and visitation shall be approved by the placing and receiving service area managers and, when appropriate, by the court.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.8(234) Out-of-state placements.

202.8(1) The department shall make an out-of-state foster family care placement only with the approval of the service area manager or designee. Approval shall be granted only when the placement will not interfere with the goals of the child's case permanency plan and when one of the following conditions exists:

a. The foster family with whom the child is placed is moving out of state.

b. An out-of-state family having previous knowledge of the child desires to provide foster care to the child.

c. An out-of-state family is approved to adopt the child under subsidy and is eligible to receive maintenance payments until the adoption is final.

d. An out-of-state placement is necessary to facilitate reunification of the child with the parents.

202.8(2) Placements shall be made in an out-of-state group care facility only with the approval of the service area manager or designee.

202.8(3) All out-of-state placements shall be made pursuant to interstate compact procedures.

202.8(4) The reasons for selecting an out-of-state placement shall be documented in the child's case permanency plan.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.9(234) Supervised apartment living. A supervised apartment living arrangement shall provide a child with an environment in which the child can experience living in the community with supervision and prepare for self-sufficiency. The child must have the capacity to live in the community with less supervision than that provided by a foster family or in a group care setting and must be able to follow the provisions of the case plan and participate in activities and services to achieve self-sufficiency.

202.9(1) *Living arrangements.*

a. The two types of supervised apartment living arrangements are as follows:

(1) A cluster setting, which provides support in a structured setting. Up to six children reside in apartments or bedrooms in one building (such as an apartment building or residential housing), supervised by one agency. The supervising agency must have an adult staff member present and available on site in the living arrangement at any time when more than one child is present.

(2) A scattered-site setting, which is the less restrictive of the two types of living arrangements. Up to three children supervised by one agency may reside in individual housing arrangements, such as apartments or residential housing, located in one building. Children must be able to contact supervising agency staff 24 hours a day, seven days a week.

b. If an agency rents an apartment to the child, there shall be a signed lease between both parties that includes, but is not limited to:

(1) Amount to be paid for the rental unit.

(2) The term of the lease with both a beginning and an ending date.

(3) Rights and responsibilities of the tenant.

(4) Rights and responsibilities of the landlord.

(5) Conditions under which the lease can be terminated.

202.9(2) *Eligibility.* To be eligible for supervised apartment living placement, a child shall meet all of the following conditions:

a. The child must be at least 16½ years old for placement in a cluster setting.

b. The child must be at least 17 years old, and it has been determined by the department or juvenile court services referral worker that the child has lived successfully in a SAL cluster setting until the child is able to live in a more independent placement in a scattered-site setting.

c. If the child is under the age of 18, the child must:

(1) Satisfactorily attend school, in accordance with the school's attendance policies, with the objective of obtaining a high school diploma; or

(2) Satisfactorily attend an instructional program, pursuant to the program's policies, necessary to obtain a high school equivalency diploma; or

(3) Attend school to obtain postsecondary education or training on a full-time basis (based upon the institution's definition of full-time) or attend on a part-time basis and be either working or participating in a work training program leading to employment; or

(4) Work at least an average of 80 hours per month if not enrolled in school; or

(5) Participate in a work training program leading to employment if not enrolled in school.

d. If the child is aged 18 or older, the child must:

(1) Meet the definition of "child" in Iowa Code section 234.1; and

(2) Have been in foster care immediately before reaching the age of 18 and have continued in foster care since reaching the age of 18. The service area manager or designee may waive the requirement for continuous placement for a child who leaves foster care at age 18 and voluntarily returns before the child's twentieth birthday in order to complete high school or obtain a high school equivalency diploma, consistent with Iowa Code sections 234.35(1)*"f"* and 234.35(3)*"c"*; and

(3) Attend school on a full-time basis leading to a high school diploma or attend an instructional program leading to a high school equivalency diploma.

e. The child must need foster care placement and services, based on an assessment completed according to rule 441—202.2(234) and subrule 202.6(5).

f. The child must participate in services and activities to achieve self-sufficiency.

g. The child must have the capacity to live in the community with less supervision than that provided by a foster family or in a group care setting, as determined by an assessment that reviews available information on the child to identify the needs, strengths, and resources of the child, especially as they pertain to the child's ability to function in the community. To determine if a supervised apartment living foster care placement is suitable for the child, the department worker must complete Form 470-4063, Preplacement Screening for Supervised Apartment Living Foster Care.

h. The child must have an approved living situation that meets the following minimum standards:

(1) Comply with applicable state and local zoning, fire, sanitary and safety regulations.

(2) Be located so as to provide reasonably convenient access to schools, places of employment, and services and supports required by the child.

(3) Be reasonably priced so as to fit within the child's budget.

i. If supervised apartment living foster care is deemed suitable for the child, the worker shall complete Form 470-3186, Request for Approval of Supervised Apartment Living Foster Care Placement, to request that the service area manager or designee approve the placement. This form is also to be used to request that the service area manager or designee waive the requirement for continuous placement for a child who leaves foster care on or after the child's eighteenth birthday and voluntarily returns before the child's twentieth birthday in order to complete high school or obtain a GED.

j. The placement must have the approval of the juvenile court if the child is under court jurisdiction.

202.9(3) *Services to be provided.* To ensure that the supervised apartment living arrangement is meeting the child's needs, required services shall be provided directly by the department or purchased from an agency that has a contract with the department to provide supervised apartment living foster care services. The following services are required:

a. Development of a case or service plan (by either the department worker or the service provider, if contracted out) in consultation with the child and the child's family (unless a reason for noninvolvement is documented in the case record) and significant others whenever appropriate that documents the following:

(1) Goals, intended to meet the specific needs of the child to achieve self-sufficiency, with projected dates of accomplishment.

(2) Objectives (action steps) to be taken by the child, the child's support system, and staff, with projected dates of accomplishment.

(3) Services to be provided and activities to be undertaken, the frequency of such services, who will provide the services, the child's progress with the goals and objectives, and the child's compliance with the service plan.

(4) A budget, developed with the child, based upon the child's monthly stipend payment, any start-up allowance, any earned or unearned incomes and financially related assistance (e.g., food assistance). Staff will work with the child to ensure payment of bills and receipt of necessary items as outlined in the budget.

b. Life skills training involving interpersonal and daily living skills training to prepare the child to maintain a safe, healthy, and stable lifestyle and achieve self-sufficiency. Life skills training includes training of "hard" skills (e.g., money management, self-care and hygiene, physical and mental health care, skills related to educational and employment goals, housing and home management, time management, accessing community resources) and training of "soft" skills (e.g., decision making, problem solving, developing healthy relationships, self-advocacy). Life skills training should be individualized to the needs of the child toward achieving self-sufficiency. If a child needs a specific life skills training service or services (e.g., parenting skill development, counseling services to reduce stress and social, emotional, or behavioral problems that affect the child's stability or ability to achieve self-sufficiency) in addition to basic life skills training services and services are purchased, the department worker will specify the necessary services under special provisions on Form 470-5081, Placement Agreement and Service Authorization for Supervised Apartment Living (SAL).

c. Through visits with the child and to the living situation, determination and documentation that:

(1) The living arrangement and mode of living are safe and suitable and provide an environment that allows for the child's social and emotional needs to be met; and

(2) There is no reasonable cause to believe that the child's living situation or mode of living presents any unacceptable risks to the child's health or safety; and

(3) The child has access to a telephone; and

(4) There is an operating smoke alarm on each level of occupancy; and

(5) The child is receiving any necessary medical care; and

(6) The child is receiving appropriate and sufficient services and supports to achieve the child's goals and facilitate objectives according to the child's service plan.

d. Supervision to assist the child in developing the needed structure to live in the supervised apartment living setting and in locating and using other needed services. If the child is under the age of 18, supervision shall include a minimum of weekly face-to-face contacts. For a child aged 18 or older, supervision shall include a minimum of biweekly (every other week) face-to-face contacts. Supervision may include guidance, oversight, and behavior monitoring.

e. Ongoing assessment activities to monitor the child's ability to achieve self-sufficiency.

f. If services are purchased, visits by the department to the child according to subrule 202.11(2).

g. If services are purchased, compliance by the provider with all reporting requirements as required by the provider's contract with the department, including requirements for the individual service plan, quarterly reports, and a termination summary.

h. A review of the case and case plan every six months, in accordance with subrules 202.6(4) and 202.6(5).

202.9(4) *Method of service provision.* Supervised apartment living services may be provided directly by the department or purchased from an agency that has a contract with the department to provide supervised apartment living foster care services. If services are purchased:

a. Department staff shall be responsible to determine the specific service components to be provided and any special provisions of this care. The department case permanency plan shall specify the goals and

objectives (action steps) of the services that are being purchased. If services are purchased, the worker shall complete Form 470-5081, Placement Agreement and Service Authorization for Supervised Apartment Living (SAL), to place the child with the contractor, to authorize the SAL service, and to identify any special provisions for the case.

b. Supervised apartment living billings shall follow the terms of the contract with the department.

202.9(5) *Termination of services.*

a. Mandatory termination. Supervised apartment living services shall be terminated when the child:

(1) No longer meets eligibility criteria;

(2) No longer needs services or needs a more restrictive level of placement;

(3) Chooses to live in a nonapproved setting; or

(4) Refuses to follow the provisions of the case plan.

b. When services are purchased and the department plans to remove a child from the supervised apartment living placement, the department shall inform the provider in writing of the date of removal, the reason for the removal, the recourse available, if any, and that the contested case (appeal) proceeding does not apply to the removal.

c. The provider shall be informed ten days in advance of the removal, except when the court orders removal of the child from the placement or there is evidence of neglect or physical or sexual abuse.

This rule is intended to implement Iowa Code section 234.6.

[**ARC 0417C**, IAB 10/31/12, effective 1/1/13; **ARC 2342C**, IAB 1/6/16, effective 2/10/16; **ARC 2885C**, IAB 1/4/17, effective 3/1/17; **ARC 3442C**, IAB 11/8/17, effective 1/1/18]

441—202.10(234) Services to foster parents. Foster parents shall be provided necessary supportive services for the purpose of aiding them in the care and supervision of the child. These services shall include but not be limited to:

202.10(1) Availability of social service staff on a 24-hour basis in case of emergency.

202.10(2) Conferences to develop in-depth planning regarding family visits, expectations of the department, future objectives and time frames, use of resources, and termination of placements. The department or the department's agent shall consider the needs and scheduling demands of a child, the child's parents, the child's siblings, and the resource parent caring for the child when scheduling supervised or any other visitation between the child and the child's siblings, family members, or fictive kin. The department shall not require a resource parent to conduct or be present during scheduled supervised visits.

202.10(3) Visitation by the service worker at least monthly regardless of the duration of the placements.

202.10(4) Notifying a resource parent of any appropriate meetings relating to the case permanency plan of a child that are known to the department, including individualized education program meetings and any medical appointments required or scheduled.

202.10(5) Making available all known pertinent information needed for the care of the child with a communicable disease, including safety-related information and special confidentiality requirements.

a. Before releasing specific information about a communicable disease, the department shall use a Communicable Diseases General Agreement to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information.

b. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. When continued breastfeeding of the child is determined to be in the best interest of the child, the service worker and the foster parents shall make reasonable efforts to support the continued breastfeeding of the child by the mother.

202.10(6) Notifying a resource parent of any change in law or regulation that is known to the department that would have a substantive impact on the resource parent's obligations and responsibilities relating to family foster care.

202.10(7) Providing a resource parent with a written report that details the conclusions of any investigation conducted by the department that may affect a resource parent's ability to provide family foster care.

202.10(8) Maintaining a process to allow a resource parent to file complaints with the department electronically.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.11(234) Services to the child. The department service worker shall maintain a continuous relationship with the child.

202.11(1) The department service worker shall:

a. Help the child plan for the future,

b. Evaluate the child's needs and progress,

c. Supervise the living arrangement,

d. Arrange for social and other related services including, but not limited to, medical, psychiatric, psychological, and educational services from other resources as needed, and

e. Counsel the child in adjusting to the placement.

202.11(2) The assigned department service worker shall personally visit each child in out-of-home care at least once every calendar month, with the frequency of the visits based upon the needs of the child.

a. The visit shall take place in the child's place of residence the majority of the time.

b. The visit shall be of sufficient length to focus on issues pertinent to case planning. During the visit, the worker shall address the safety, permanency, and well-being of the child, including the child's needs, services to the child, and achievement of the case permanency plan goals.

202.11(3) When placement of a breastfeeding child is made, the service worker shall:

a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;

b. Make every reasonable effort to support the mother's continued breastfeeding for the child if determined appropriate; and

c. Document the assessment and efforts in the child's case plan and case notes.

202.11(4) When a child is in continuous foster care, a new physical examination shall not be required when the child transfers from one foster care placement to another unless there is some indication that an examination is necessary. The service worker shall obtain from the health practitioner or practitioners an annual medical review of treatment the child has received.

202.11(5) Throughout the provision of care, the foster care provider shall actively ensure that the child stays connected to the child's kin, culture, and community as documented in the child's case permanency plan. A resource parent shall be allowed to provide family foster care according to the resource parent's own culture and beliefs if such resource parent does not actively discourage a child to disregard the child's own culture and beliefs and if a biological parent whose parental rights have not been terminated or a legal guardian for the child does not object to the practice or activity that is consistent with the resource parent's own culture and beliefs.

202.11(6) Throughout the provision of care, the foster care provider is permitted to use the reasonable and prudent parent standard to create opportunities for participation of the child in age- or developmentally appropriate activities.

202.11(7) Transition planning program. The purpose of the transition planning program is to provide services, supports, activities and referrals to programs that assist children currently or formerly in foster care in acquiring skills and abilities necessary for transition to successful adulthood. The transition planning program offers a life skills assessment, transition plan development, and transition-related services, supports, activities and referrals to programs.

a. Eligibility. To be eligible for the transition planning program, a child must be or have been in foster care as defined by rule 441—202.1(234) or 45 Code of Federal Regulations 1355.20 as amended to October 1, 2008, and must meet at least one of the following eligibility requirements:

(1) Is currently in foster care and is 14 years of age or older.

(2) Is under the age of 21 and was adopted from foster care at 16 years of age or older.

(3) Is under the age of 21 and was placed in a subsidized guardianship arrangement from foster care at 16 years of age or older.

(4) Was formerly in foster care and is eligible for and participating in Iowa's aftercare services program as described at 441—Chapter 187.

(5) Was formerly in foster care and is eligible for and participating in Iowa's postsecondary education and training voucher (ETV) program as described at 42 U.S.C. Section 677(a)(6-7).

b. Assessment. A life skills assessment shall be administered to all children in foster care who are aged 14 or older. An assessment shall be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph *"a."* The assessment is designed to evaluate the child's strengths and needs in areas including, but not limited to:

(1) Education,

(2) Physical and mental health,

(3) Employment,

(4) Housing and money management, and

(5) Supportive relationships.

c. Transition plan development. A transition plan shall be completed for all children in foster care who are aged 14 or older, as provided in Iowa Code section 232.2(4)*"f."* Transition plan development shall also be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph *"a,"* but the transition plan will not be part of a case permanency plan. Transition plan requirements include the following:

(1) The transition plan shall be personalized at the direction of the child and shall be developed in consultation with the child and reviewed by the department in collaboration with a child-centered transition team, honoring the goals and concerns of the child.

(2) The transition plan shall document that the child received and signed a document that describes the rights of the child with respect to education, health, visitation, and court participation. The document must be signed by the child indicating that the child has been provided with a copy of the document and that the rights contained in the document have been explained to the child in an age-appropriate way.

(3) The transition plan shall document that the child received a copy of any credit report pertaining to the child as provided by the child's caseworker on an annual basis until the child is discharged from foster care. The child must receive assistance from the child's caseworker in interpreting and resolving any inaccuracies in the report.

(4) The transition plan shall document that any child leaving foster care at the age of 18 or older was provided with the following documents and information unless the child has been in foster care for less than 30 days or is not eligible to receive such document:

1. An official or certified copy of the child's birth certificate.
2. The child's social security card.
3. A driver's license or identification card issued by the state to the child.
4. Health insurance information.
5. A copy of the child's medical and education records.

(5) The transition plan shall document that the caseworker provided to the child, at the case permanency plan review in the 90 days before the child reached the age of 18, information and education about the importance of having a durable power of attorney for health care and a copy of the state's form used to identify such a proxy. The child has the option to complete the form at the age of 18 or older.

(6) The transition plan shall address the strengths and needs identified in the assessment and detail the services, supports, activities and referrals to programs needed to implement the plan to best assist the child in preparing for successful adulthood. The membership of the transition team and the meeting dates for the team shall be documented in the transition plan.

(7) The transition plan shall be reviewed and updated at each case review after the plan's initial development; within 90 days before the child's eighteenth birthday; and within 90 days before the child is expected to leave foster care if the child remains in care after reaching the age of 18.

d. Transition services. Children shall be offered services, supports, activities and referrals to programs within, but not limited to, the five areas described below according to the child's age and

development, strengths and needs, permanency goal, and placement as documented in the case permanency plan.

(1) Education skills increase the child's chances of completing high school or obtaining high school equivalency and of entering a satisfying career. Services may include assistance in academic advising and guidance, secondary and postsecondary educational support, records transfer coordination, tutoring, financial aid planning, career exploration, mentoring, and career advising. Financial assistance for postsecondary education and training may be available to eligible children.

(2) Physical and mental health skills promote healthy physical, mental and emotional functioning. Health education services may include guidance on risk prevention, how to be healthy and fit, how to self-advocate for health care needs and access to health insurance, how to select medical professionals, and how to make informed decisions regarding treatment, lifestyle considerations, spirituality, and recreation. Provision must be made for the child's application for adult services if it is likely the child will need or be eligible for services or other support from the adult service system.

(3) Employment skills enable children to prepare for, seek, and maintain gainful career employment. Services may include employment programs or vocational training, employment search resources, career advising, résumé writing, interview skills, workplace etiquette, and on-the-job training.

(4) Housing and money management skills prepare a child to select, manage, and maintain safe and stable housing. Services may include lessons on the physical maintenance and cleaning of a house and guidance on managing personal finances, such as financial decisions, budgeting, bill paying, use of credit, and financing. Financial assistance for items, including room and board, may be available to children who meet the eligibility criteria of the aftercare services program pursuant to 441—Chapter 187.

(5) Supportive relationships skills promote the healthy development and maintenance of rewarding, lasting relationships. Services may include family support and healthy marriage education, mentoring opportunities, and guidance on how to recognize the needs of others, how to identify and understand personal motivations, how to ensure personal safety, and how to communicate effectively.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8718B**, IAB 5/5/10, effective 7/1/10; **ARC 0417C**, IAB 10/31/12, effective 1/1/13; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.12(234) Services to parents.

202.12(1) Child welfare services shall be made available to the parents throughout the period of placement for the purpose of reuniting the family in an agreed-upon time frame. Family safety, risk, and permanency services may be provided to:

a. Promote identification and enhancement of family strengths and protective capacities;

b. Address the factors that resulted in the child's being removed from the family home; and

c. Strengthen family connections to community resources and informal supports.

202.12(2) Placement notification.

a. The parents shall be notified of the location and nature of the child's placement, unless the conditions of this subrule are met.

(1) The department evaluates the situation and determines that notifying the child's parents of the location of the placement would be detrimental to the child's safety and well-being and to the stability of the child's placement due to:

1. Evidence of a direct or indirect threat to harm the foster child or the foster family; or
2. Credible third-party information of a threat of harm to the foster child or the foster family.

(2) The department includes a statement in the child's case permanency plan explaining the decision not to disclose the location of the child to the parents.

b. The decision not to disclose the location of a child's placement shall be reviewed at least every six months when the child's case permanency plan is revised.

202.12(3) The case plan and treatment plan shall specify the services to be provided and the time frame for reuniting the family. These plans shall be developed in cooperation with the parents.

202.12(4) Personal contact shall be made regularly with the parents and the progress towards goal attainment reviewed and documented in the case record. The frequency of the personal contact shall be at least monthly and shall be specified in the child's case permanency plan.

202.12(5) When placement of a breastfeeding child is made, the service worker shall:

a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;

b. Make every reasonable effort to support the mother's continued breastfeeding of the child if determined appropriate; and

c. Document the assessment and efforts in the child's case plan and case notes.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 9961B**, IAB 1/11/12, effective 12/15/11]

441—202.13(234) Removal of the child.

202.13(1) When the department plans to remove a child from a facility or foster home, the facility or foster home shall be informed in writing of the date of the removal, the reason for the removal, the recourse available to the facility or foster home, if any, and that the contested case proceeding pursuant to Iowa Code chapter 17A is not applicable to the removal. The department shall inform the facility or foster home ten days in advance of the removal, except that the facility or foster home may be informed less than ten days prior to the removal in the following instances:

a. When the parent or guardian removes the child from voluntary placement.

b. When the court orders removal of a child from placement.

c. When there is evidence of neglect or physical or sexual abuse.

202.13(2) The department may remove a child from a facility or foster home when any of the following conditions exist:

a. There is evidence of abuse, neglect, or exploitation of the child.

b. The child needs a specialized service that the facility does not offer.

c. The child is unable to benefit from the placement as evidenced by lack of progress of the child.

d. There is evidence the facility is unable to provide the care needed by the child and fulfill its responsibilities under the case plan.

e. There is lack of cooperation of the facility or foster home with the department.

202.13(3) If a foster family objects in writing within seven days from the date that the department furnishes notice of plans to remove the child, the service area manager or designee shall grant a conference to the foster family to determine whether the removal is in the child's best interest.

a. This conference shall not be construed to be a contested case under Iowa Code chapter 17A.

b. The conference shall be provided before the child is removed except in instances listed in paragraphs 202.13(1)*"a"* to *"c."* The service area manager or designee shall review the propriety of the removal and explain the decision to the foster family.

c. The service area manager or designee, on finding that the removal is not in the child's best interests, may overrule the removal decision unless a court order or parental decision prevents the department from doing so.

202.13(4) When the facility or foster home requests a child be removed from its care, it shall give a minimum of ten days' notice to the department so planning may be made on behalf of the child. This does not apply to a situation where the health or safety of the child or another person in the foster home is threatened by the child's presence in the child's current placement home.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.14(234) Termination. The foster care services shall be terminated when the child is no longer an eligible child, or when the attainment of goals in the case plan has been achieved, or when the goals for whatever reasons cannot be achieved, or when it is evident that the family or individual is unable to benefit from the service or unwilling to accept further services.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.15(234) Case permanency plan.

202.15(1) The department worker shall ensure that a case permanency plan is developed for each child who is placed in foster care if the department has agreed to provide foster care through a voluntary placement agreement, if a court has transferred custody or guardianship to the department for the purpose of foster care, or if a court has placed the child in foster care and ordered the department to supervise the placement.

202.15(2) The department worker shall develop the case permanency plan with the child's parents, unless the child's parents are unwilling to participate in the plan's development, and with the child, unless the child is unable or unwilling to participate. For a child 14 years of age or older in foster care, the case permanency plan must be developed in consultation with the child. The child may choose up to two members of the case planning team who are not the child's foster parent or caseworker. The department may reject an individual selected by a child at any time if the department has good cause to believe the individual would not act in the best interests of the child. One individual selected by the child to be a member of a child's case planning team may be designated to be the child's advisor and, as necessary, advocate with respect to the use of the reasonable and prudent parent standard.

202.15(3) The department shall consider information regarding medical appointments, treatment needs, educational progress, and services from a resource parent when developing or modifying a child's case permanency plan and in the coordination of care and decisions related to services and care necessary for the child. The information the department receives from a resource parent will be reviewed and considered as decisions about the child's progress and needs are made.

202.15(4) The department worker shall be responsible for ensuring the development of the case permanency plan within the time frames specified in rule 441—130.7(234). In all cases, the case permanency plan shall be completed within 60 days of the date the child entered foster care.

202.15(5) Copies of the initial and subsequent case permanency plans shall be provided to the child, the child's parents, and the foster care provider. Copies shall also be provided to the following, if involved in services to the child: the juvenile court officer, the judge, the child's attorney, the child's guardian ad litem, the child's guardian, the child's custodian, the child's court-appointed special advocate, the parents' attorneys, the county attorney, the state foster care review board, and any other interested parties identified in the plan.

202.15(6) The initial and subsequent case permanency plans shall be completed on the forms specified in rule 441—130.7(234).

This rule is intended to implement Iowa Code section 135H.6.

[**ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.16(135H) Department approval of need for a psychiatric medical institution for children.

202.16(1) Applicants for departmental approval of need shall submit the following to the division of child and family services:

a. A description of the population to be served, including age, sex, and types of disorders, and an estimate of the number of these youth in need of psychiatric care in the area of the state in which the applicant is located.

b. A statement of the number of beds requested and a description of the treatment program to be provided, the outcomes to be achieved and the techniques for measuring outcomes.

c. A proposed date of operation as a psychiatric medical institution for children.

d. A description of the applicant's experience with providing similar services to youth, especially the target population.

e. A description of the applicant's plan, including the timeline for achieving accreditation to provide psychiatric services from a federally recognized accrediting organization under the organization's standards for residential settings and licensure as a psychiatric medical institution for children, or a copy of the organization's report if already accredited.

f. References from the service area manager for the department service area in which the proposed psychiatric medical institution for children would be located, the chief juvenile court officer of the judicial district in which the proposed psychiatric medical institution for children would be located and the applicant's licensor from the department of inspections and appeals or department of public health.

202.16(2) The department shall evaluate proposals and issue a decision based on the following criteria:

a. The number of psychiatric medical institutions for children beds for the proposed population which are needed in the area of the state in which the facility would be located, based on the department's most recent needs assessment.

b. The steps the facility has taken towards achieving accreditation from a federally recognized accrediting organization and licensure as a psychiatric medical institution for children.

c. The applicant's ability to provide services and support consistent with the requirements under Iowa Code chapter 232 including, but not limited to, evidence that:

(1) Children will be served in a setting which is in close proximity to their parents' home.

(2) Each child will receive services consistent with the child's best interests and special psychiatric needs as identified in the child's case permanency plan.

(3) Children and their families will receive services to facilitate the children's return home or other permanent placement.

d. The applicant's ability to provide children with a non-hospital-type living environment if the applicant is not freestanding from a hospital or health care facility.

e. The limits on the number of beds found in Iowa Code section 135H.6(5).

202.16(3) If a facility has not been licensed as a psychiatric medical institution for children within one year after the date of the department's approval of need, the department's approval shall expire unless the department has approved an extension. An extension may be approved up to a maximum of six months if the agency has documented extenuating circumstances which prevented completion of the licensing process.

This rule is intended to implement Iowa Code section 135H.6.

[**ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.17(232) Area group care targets.

202.17(1) *Area target.* A group care budget target shall be established for each departmental service area, which shall be based on the annual statewide group care appropriation established by the general assembly.

a. The department and the judicial branch shall jointly develop a formula for allocating the group care appropriation among the departmental service areas. The formula shall be based on:

(1) Proportional child population.

(2) Proportional group foster care usage in the previous five completed fiscal years.

(3) Other indicators of need.

b. Any portion of the group care appropriation allocated for 50 highly structured juvenile program beds and not used may be used for group care.

c. Upon written agreement of the affected service area managers and chief juvenile court officers, service areas may transfer part of their group care budget from one service area to another. A service area may exceed its budget target figure up to 5 percent during the fiscal year, providing that the overall funding allocation by the department for all child welfare services in the service area is not exceeded.

d. Notwithstanding the statewide appropriation established in this subrule, a budget established in a service area's group care plan pursuant to Iowa Code section 232.143 may be exceeded, a group care placement may be ordered, and state payment may be made if the review organization finds that the placement is necessary to meet the child's service needs and if the service area has additional funds transferred from another service area or if the service area is within 5 percent of its group care budget target figure pursuant to 441—paragraph 202.17(1)*"c."*

The department and juvenile court services shall work together to ensure that a service area's group care expenditures shall not exceed the funds allocated to the service area for group care in the fiscal year.

e. If at any time after September 30, 1998, annualization of a service area's current expenditures indicates a service area is at risk of exceeding its group foster care expenditure target under Iowa Code section 232.143 by more than 5 percent, the department and juvenile court services shall examine all group foster care placements in that service area in order to identify those which might be appropriate for

termination. In addition, any aftercare services believed to be needed for the children whose placements may be terminated shall be identified.

The department and juvenile court services shall initiate action to set dispositional review hearings for the placements identified. In the dispositional review hearing, the juvenile court shall determine whether needed aftercare services are available and whether termination of the placement is in the best interest of the child and the community.

202.17(2) *Plan for achieving target.* For each of the departmental service areas, representatives appointed by the department and juvenile court services shall establish a plan for containing the expenditure for children placed in group care within the budget target allocated to that service area. The plan shall include monthly targets and strategies for developing alternatives to group care placements.

The plans shall also ensure potential group care referrals are reviewed by the review organization prior to submission of a recommendation for group care placement to the court.

Each area plan shall be established in advance of the fiscal year to which the plan applies. To the extent possible, the department and the juvenile court shall coordinate the planning required under this subrule with planning for services paid under Iowa Code section 232.141(4). The department's service area manager shall communicate regularly, as specified in the area plan, with the juvenile courts within the service area concerning the current status of the plan's implementation.

This rule is intended to implement Iowa Code section 232.143.

[**ARC 8197C**, IAB 8/21/24, effective 10/1/24]

441—202.18(235) Local transition committees. Local transition committees shall be established in each of the department service areas. The service area manager or designee shall determine the number of local transition committees needed within the service area, set operating policies and procedures, and appoint committee membership.

202.18(1) *Purpose.* The purpose of local transition committees, as established by Iowa Code Supplement section 235.7, is to ensure that the transition needs of youth in foster care who are 16 years of age or older have been addressed in order to assist the youth in preparing for the transition from foster care to adulthood.

202.18(2) *Membership.* Each committee shall have a designated number of members.

a. The standing committee membership may include, but is not limited to:

(1) Department staff involved with child welfare, adult services, or transition planning.

(2) Juvenile court services staff.

(3) Adult service system staff.

(4) Education staff.

(5) Service care provider representation.

(6) Others knowledgeable about community resources.

b. Additionally, nonstanding membership may include those knowledgeable about the youth, including the child's court-appointed special advocate, guardian ad litem, and service or care providers.

c. In areas where teams or boards already in existence are involved in review and planning for youth needs, such as the foster care review board or child welfare funding decategorization boards, such teams or boards may serve as local transition committees.

202.18(3) *Duties.* Local transition committees shall address the transition needs of youth in foster care who are 16 years of age or older and who have a case permanency plan as defined in Iowa Code Supplement section 232.2. Each committee shall have operating policies and procedures to carry out the duties below.

a. Each committee shall establish a process for review and approval of written transition plans for youth for whom the committee has placement responsibility that meets a continuum of case needs and coordinates with local transition planning protocol. The process may include a paper review or an in-person review, or both, according to case need.

b. The committee may be involved when the youth is at least 16 years of age, but shall be involved in reviewing and approving a youth's transition plan before the youth reaches age 17½. When a youth enters foster care at age 17½ or older, the committee shall be involved in reviewing and approving the youth's transition plan within 30 days of completion.

c. In reviewing a youth's transition plan, the committee shall identify and act to address gaps existing in services or supports available that would assist the youth in the transition from foster care to adulthood.

d. For those youth expected to need services as adults, the committee shall ensure that the transition plan was developed with the participation of any person reasonably expected to be a service provider when the youth becomes an adult or to become responsible for the costs of services at that time.

e. The committee shall ensure that transition planning and review is coordinated with overall case planning and review. Committee review and approval shall be indicated in the youth's case permanency plan.

f. With respect to meetings involving a specific youth receiving foster care and the youth's family, the local transition committees are not subject to Iowa Code chapter 21.

g. The information and records of or provided to a local transition committee regarding a youth receiving foster care and the youth's family are not public records pursuant to Iowa Code chapter 22 when the records relate to the foster care placement and transition needs of the youth.

h. Members of the committees are subject to the standards of confidentiality set forth in Iowa Code sections 600.16, 217.30 and 235A.15.

202.18(4) *Report.* The service area manager or designee shall submit a report on transition planning committees to the department's division of child and family services. The report shall be submitted annually by October 1 for the immediately preceding fiscal year. The report shall include, but not be limited to, the following:

a. The geographical area covered for each committee within the service area.

b. Standing committee membership for each committee.

c. The number of cases reviewed by each committee.

d. Identification of barriers to successful transition and gaps in community services or supports.

e. Suggestions for ways to transition youth from foster care to adulthood more effectively.

This rule is intended to implement Iowa Code section 235.7.

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CHAPTER 203
IOWA ADOPTION EXCHANGE

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

441—203.1(232) Definitions.

"Children who are difficult to place" means "child" as described in 441—subrule 201.3(1), children under state guardianship for whom an adoptive home is not available within 90 days after termination and children as part of a sibling group of more than three children.

"Iowa adoption exchange system" or *"exchange system"* is a computerized system established to facilitate the adoptive placement of children by matching children legally available for adoption and approved families desiring to adopt a child who is difficult to place.

"Recruitment, retention, training and support (RRTS) contract" means the state's contractor(s) responsible for activities related to licensing foster families and approving adoptive families, providing support services to foster and preadoptive families, conducting preservice and in-service training, and assisting in matching children in need of foster home care.

[**ARC 8069C**, IAB 6/12/24, effective 7/17/24]

441—203.2(232) Children to be registered on the exchange system.

203.2(1) All children who are difficult to place shall be registered on the exchange system within 60 days of receipt of the termination of parental rights court order unless a deferral is granted by the adoption program manager.

203.2(2) Licensed child-placing agencies shall register a child whose parental rights have been terminated and who is under their guardianship using one of the following methods:

a. If the agency is registering fewer than four children in a calendar year, the agency shall submit the Waiting Child Enrollment form to the department.

b. If the agency registers more than three children in a calendar year, the agency shall access the exchange system and enter the child's name and data.

[**ARC 8069C**, IAB 6/12/24, effective 7/17/24]

441—203.3(232) Families to be registered on the exchange system.

203.3(1) Approved families wishing to adopt a child who is difficult to place shall be registered on the exchange system by the department.

203.3(2) Licensed child-placing agencies and certified adoption investigators shall register an approved family on the exchange using one of the following methods:

a. If the licensed child-placing agency is registering fewer than four families in a calendar year, the agency shall submit the Exchange Referral of Family form to the department.

b. If the licensed child-placing agency registers more than three children in a calendar year, the agency shall access the exchange system and enter the family's name and data.

c. Certified adoption investigators shall submit the Exchange Referral of Family form to the department.

[**ARC 8069C**, IAB 6/12/24, effective 7/17/24]

441—203.4(232) Matching process. Using the computerized exchange system, the department and licensed child-placing agencies shall search for approved families to meet the needs of the available children. The child's and family's workers shall be contacted for additional information needed to make an informed decision concerning possible adoptive placements.

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These rules are intended to implement Iowa Code section 232.119.

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CHAPTER 204
SUBSIDIZED GUARDIANSHIP PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/14/29

441—204.1(234) Definitions.

"Child" means either a person less than 18 years of age or a person 18, 19, or 20 years of age who meets one or more of the following conditions:

1. Is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma.
2. Is attending an instructional program leading to a high school equivalency diploma.
3. Has been identified by the director of special education of the area education agency as a child requiring special education as defined in Iowa Code section 256B.2(1).

"Guardianship subsidy" means a monthly payment to assist in covering the cost of room, board, clothing, and spending money for the child.

"Nonrecurring expenses" means reasonable and necessary guardianship fees, court costs, attorney fees, and other expenses that are directly related to finalizing the legal guardianship of a child. These expenses shall be limited to attorney fees, court filing fees and other court costs.

"Relative" means a person to whom a child is related by blood, marriage, or adoption, or a person who has a significant, committed, positive relationship with the child.

"Sibling group" means at least two children who are whole or half-siblings. A sibling group may include adopted children who have a common parent.

[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

441—204.2(234) Eligibility.

204.2(1) *General conditions of eligibility.* The guardian named in a permanency order under Iowa Code section 232.104(2)*"d"*(1) or chapter 232D for a child who was previously in the custody of the department is eligible for subsidy when all of the following conditions exist:

a. The child has a documented permanency goal of:

(1) Guardianship; or

(2) Another planned permanent living arrangement.

b. The child is either:

(1) Ten years of age or older and consents to the guardianship; or

(2) Part of a sibling group with a child aged ten or older.

c. The child has lived in continuous foster family care with the prospective guardian for the six months before initiation of the guardianship subsidy.

d. The prospective guardian is a licensed relative foster parent who has a significant relationship with the child and demonstrates a willingness to make a long-term commitment to the child's care.

(1) The guardian shall be a relative as defined in this chapter.

(2) Placement with that guardian must be in the best interest of the child. The best-interest determination must be documented in the case file.

e. A child who is part of a sibling group with a child ten years of age or older may be eligible for subsidy if all criteria are met. The following conditions for the younger sibling shall also be met:

(1) The sibling is placed as a foster child in the same prospective guardian home.

(2) The guardian and the department agree it is appropriate for guardianship to be granted for the sibling.

204.2(2) *Residency.* The subsidized guardianship applicant or recipient need not reside in Iowa.

204.2(3) *Unearned income.* The family or the guardian shall provide to the department documentation from the source of the child's unearned income.

204.2(4) *Other services.* Other services available to meet the needs of the child that are free of charge, such as federal, state, and local governmental programs, or private assistance programs, shall be explored and used prior to the expenditure of subsidized guardianship funds.

[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

441—204.3(234) Application. Applications for the subsidized guardianship program may be made at any county office of the department.

204.3(1) *Application forms.* Application for a subsidized guardianship shall be made on the approved department form.

204.3(2) *Eligibility determination.* The determination of whether a child meets the eligibility requirements is made by the department. The proposed guardian shall be notified in writing of the decision of the department regarding the child's eligibility for the program and the amount of subsidy to be provided.

204.3(3) *Effective date.* The effective date of the guardianship subsidy payment shall be the date the guardianship order is signed if all other conditions of eligibility are met.

204.3(4) *Redetermination.* The department shall review the child's eligibility, the needs of the child and the child's unearned income every 12 months. Reviews may be done more often if needed due to the child's need for special services, revision of the subsidy amount because of the child's age, or a request for review by the guardian.

204.3(5) *Determination of eligibility after age 18.* The department shall review the subsidy agreement when the child reaches the age of 17½ to determine whether the child is eligible to receive a subsidy to the age of 21 to complete high school or equivalency or due to the child's physical, intellectual, or mental health disability.

a. A disability shall be diagnosed by a physician, a qualified mental health professional or a qualified intellectual disability professional.

b. The diagnosed disability shall be current within one year prior to the child's eighteenth birthday.

c. Documentation of the child's diagnosed disability shall be provided by the child's guardian to the department.

d. Upon the child's reaching the age of 18, the subsidy may continue until the child completes courses leading to a high school diploma or equivalency or reaches the age of 21. Documentation of school enrollment and completion shall be provided by the child's guardian.

[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

441—204.4(234) Negotiation of amount of subsidy.

204.4(1) *Subsidy agreement.* The amount of subsidy shall be negotiated between the department and the guardian and shall be based upon the needs of the child and the circumstances of the family.

204.4(2) *Amount of subsidy.* Each time negotiations are completed, the department and the guardian shall complete and sign a new Guardianship Subsidy Agreement.

a. The maximum monthly maintenance payment for a child in subsidized guardianship shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found in 441—subrule 156.6(4).

(1) The rate for the guardianship subsidy shall not exceed the state's current daily basic foster care rate plus any daily special needs allowance or sibling allowance for which the child is eligible, as found in 441—subrule 156.6(4).

(2) Reserved.

b. If the subsidized guardianship payment is less than the maximum amount allowed, the guardian may request an increase if there is a substantial change in the child's needs and circumstances that requires additional resources.

c. Guardianship payments shall continue if the guardian dies or becomes incapacitated and has named a successor guardian in the Guardianship Subsidy Agreement or in any amendments to the agreement.

204.4(3) *Placement outside of home.* If a child needs to be placed out of the guardian's home and the plan is for the child to return to the guardian within six months, a partial subsidy amount may be negotiated.

204.4(4) *Nonrecurring expenses.* The nonrecurring expenses necessary to finalize a guardianship shall not exceed $2,000.

204.4(5) *Special services.*

a. Reimbursement to the guardian family or direct payment made to a provider is limited to the following services:

(1) Outpatient individual or family services provided from a non-Medicaid provider only with approval from the department and when one of the following applies:

1. The services are not available from a Medicaid provider within a reasonable distance from the family.

2. The child and the family were receiving therapy or counseling from a non-Medicaid provider and it would not be in the child's best interest to disrupt the services.

3. Available Medicaid providers lack experience in working with foster, adopted, or blended families.

(2) Travel-related expenses including transportation, meals and lodging not covered by Medicaid for visitation or family therapy when the child is receiving Medicaid-paid services out of the home.

(3) Supplies and equipment as required by the child's special needs and unavailable through other resources.

(4) Funeral benefits at the amount allowed for a foster child in accordance with rule 441—156.8(234).

b. Any single special service and any special service delivered over a 12-month period costing $500 or more shall have prior approval from the department prior to expending program funds.

c. For all Medicaid-covered services, the department shall reimburse at the same rate and duration as Medicaid as set forth in rule 441—79.1(249A).

[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

441—204.5(234) Parental liability. These subsidy payments are considered foster care payments for purposes of child support recovery and as such create a support debt for the legally responsible parent or parents.

[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

441—204.6(234) Determination of ongoing subsidy eligibility and suspension of subsidy payments.

204.6(1) Eligibility for continuation of guardianship subsidy shall be evaluated when the department has good cause to suspect the guardian is not providing financial support or is no longer legally responsible for the child. Good cause includes, but is not limited to, the following circumstances:

a. The child is placed in out-of-home care under Iowa Code chapter 232.

b. A person alleges the guardian is not providing financial support to the child.

c. A person other than the guardian is awarded legal custody of the child.

d. A person other than the guardian is appointed as the guardian of the child.

e. The child has applied for food assistance or other benefits.

f. The child has not resided with the guardian for the past 30 consecutive days.

g. The guardian is incarcerated.

h. The guardian is awaiting trial for criminal charges related to harm caused to a child in the home.

204.6(2) The department will contact the child's guardian via letter, telephone, or electronic or other means and document such efforts if an evaluation is determined to be necessary.

204.6(3) If such an evaluation occurs, the child's guardian shall provide documentation of support, including receipts, to the department upon request.

204.6(4) Upon completion of the department's evaluation of the child's continued eligibility for guardianship subsidy, the department will issue a written notice to the guardian documenting required ongoing actions by the guardian, including an expectation of continued cooperation by the guardian to provide documentation of ongoing support to the child at the request of the department.

204.6(5) The department shall suspend guardianship subsidy payments if the guardian refuses to cooperate with any department evaluation designed to determine legal responsibility for the child or to determine whether the guardian is providing financial support for the child.

204.6(6) Through a Notice of Decision, the department will notify the guardian that the guardianship subsidy payment will be suspended, modified, or terminated.

204.6(7) When the child has resided out of the guardian's home for 30 consecutive days, the department shall request a renegotiation of the Guardianship Subsidy Agreement with the guardian to reduce or suspend payments as agreed to by the guardian.

[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

441—204.7(234) Termination of subsidy. A Guardianship Subsidy Agreement remains in effect until the subsidy is terminated. The subsidy shall terminate when any of the following occur, and a notice shall be sent that states the reason for the termination:

1. The child reaches the age of 18, unless the department determines that the subsidy may continue until the child reaches the age of 21 as specified by subrule 204.3(5).
2. The child marries or enlists in the military.
3. The child no longer lives with the guardian, except for placement outside the home as limited by subrule 204.4(3).
4. The relationship ends due to the death of the child.
5. The terms of the Guardianship Subsidy Agreement are concluded.
6. The guardian requests that the guardianship payment cease.
7. The department has determined the guardian is not providing financial support to the child.
8. The guardian fails to abide by the terms of the Guardianship Subsidy Agreement.
9. The guardianship case is terminated by court order.
10. The department funds for subsidized guardianship are no longer available.
11. Due to incapacity, the guardian can no longer discharge the responsibilities necessary to protect and care for the child, the guardianship has been or will be vacated, and a successor guardian was not named in the Guardianship Subsidy Agreement.
12. The death of the guardian when a successor guardian is not named in the Guardianship Subsidy Agreement (one in a single-parent family or both in a two-parent family).

[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

441—204.8(234) Reinstatement of subsidy. Reinstatement of the subsidy shall be made when the subsidy was terminated at the guardian's request and the guardian has requested reinstatement.
[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

441—204.9(234) Appeals. The guardian may appeal adverse determinations pursuant to 441—Chapter 2506.
[**ARC 8111C**, IAB 7/10/24, effective 8/14/24; Editorial change: IAC Supplement 6/10/26]

441—204.10(234) Medical assistance.

204.10(1) Children eligible for subsidy are entitled to medical assistance as defined in 441—Chapter 75. When an Iowa child receives medical assistance from another state, Iowa shall discontinue paying any medical costs the month following the move unless additional time is necessary for a timely notice of decision to be provided to the guardian.

204.10(2) The funding source for medical assistance is based on the following criteria:

a. Children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

b. Children from Iowa residing in another state shall receive medical assistance from the state of residence if eligible. Iowa shall provide medical assistance for children not eligible in their state of residence. Medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

c. Children from another state residing in Iowa shall continue to be covered by the other state's medical assistance unless the state has adopted the adoption assistance interstate compact and a contract between Iowa and the other state exists.

[**ARC 8111C**, IAB 7/10/24, effective 8/14/24]

These rules are intended to implement Iowa Code section 234.6 and 2006 Iowa Acts, House File 2734, section 17, subsection 11.

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

CHAPTER 205
Reserved

CHAPTER 206
COMMUNITY SUPERVISED APARTMENT LIVING ARRANGEMENTS SERVICES PROGRAM
Rescinded IAB 3/6/02, effective 5/1/02

CHAPTER 207
RESIDENTIAL SERVICES FOR ADULTS
Rescinded IAB 3/6/02, effective 5/1/02

CHAPTER 208
Reserved

CHAPTER 209
CHILDREN IN NEED OF ASSISTANCE OR CHILDREN FOUND TO HAVE COMMITTED A DELINQUENT ACT
Rescinded IAB 11/1/89, effective 1/1/90. See 441—Ch 151

TITLE XVII
AGING AND DISABILITY SERVICES

CHAPTERS 210 to 220
Reserved

CHAPTER 221
DISABILITY SERVICES DEFINITIONS

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

441—221.1(225A) Definitions. For the purpose of this chapter and 441—Chapters 222 through 224 and 229, the following definitions apply:

"Adult" means a person or persons 18 years of age and over.

"Caregiver" means an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation. "Caregiver" also means a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition.

"Chairperson" means the chairperson of the disability services advisory council who has been appointed by the DAP.

"Child" or *"children"* means a person or persons under 18 years of age.

"Disability" means the same as defined in Section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. §12012 as amended to July 1, 2025).

"Disability access point" or *"DAP"* means a local organization designated by the department to serve as the primary access point for people with disabilities and their caregivers. DAPs serve as aging and disability resource center (ADRC) member organizations as defined in rule 441—224.1(231).

"Disability services advisory council" or *"DSA council"* means a council established by each DAP to identify opportunities, address challenges, and advise the DAP.

"Long-term services and supports" or *"LTSS"* means activities that support maintaining people with disabilities at the lowest level of care possible, including facility diversion or transition to community as determined through the DAP processes for eligibility and service determination. LTSS will be outlined in the individual's service plan between the individual, care team, and DAP.

"Service coordination" means an active, transitional, and ongoing process that involves assisting an eligible individual in gaining access to and coordinating the provision of services, using person-centered practices in all contacts with individuals and their caregivers, and coordinating the services identified in the service plan.

"Short-term services and supports" or *"STSS"* means time-limited activities focused on supporting people with disabilities to live in the home and community of their choice in an integrated manner and offering support to their families and caregivers as needed toward this purpose. STSS will be outlined in the individual's service plan between the individual, care team, and DAP.

This rule is intended to implement Iowa Code section 231.23.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

[Filed ARC 9282C (Notice ARC 9018C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTER 222
DISABILITY SERVICES ADVISORY COUNCILS

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

441—222.1(231) Appointment.

222.1(1) The members of a council will be recruited by the DAP.

222.1(2) The appointments will be for three-year staggered terms, which will expire on June 30.

222.1(3) Vacancies will be filled in the same manner in which the original appointments were made for the balance of the unexpired term.

222.1(4) Absences.

a. Three unexcused absences in a 12-month period constitutes grounds for the DAP to request nomination of an alternate representative to fill the position.

b. Absences may be excused by notification provided to the chairperson prior to the meeting.

c. The chairperson of a council is charged with providing notification of absences to the DAP.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—222.2(231) Officers.

222.2(1) Officers of a council will consist of a chairperson and a vice chairperson. The chairperson will be appointed by the DAP. The vice chairperson will be elected at the first meeting of each fiscal year.

a. The vice chairperson may serve no more than three consecutive terms.

b. Vacancies in the office of chairperson will be filled by elevation of the vice chairperson for 60 days until a new appointment can be made by the DAP.

c. Vacancies in the office of vice chairperson will be filled by election at the next meeting after the vacancy occurs.

d. A vacancy must be filled by an individual meeting the same qualifications as the departing council member in accordance with Iowa Code chapter 231.

222.2(2) Duties of officers.

a. The chairperson will:

(1) Preside at all meetings of the council;

(2) Appoint subcommittees as deemed necessary; and

(3) Designate the chairperson of each subcommittee.

b. The vice chairperson will:

(1) Perform the duties of the chairperson if the chairperson is absent or unable to act. When so acting, the vice chairperson will have all the powers of and be subject to all restrictions upon the chairperson.

(2) Perform other duties as may be assigned by the chairperson.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—222.3(231) Meetings.

222.3(1) A council will establish a meeting schedule on an annual basis to conduct its business. There will be a minimum of four meetings per year.

222.3(2) A majority of appointed members constitutes a quorum.

222.3(3) When a quorum is present, a position is carried by an affirmative vote of the majority of those present. No official business that requires a vote of the membership will be conducted without a quorum present.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—222.4(231) Subcommittees. A council may designate one or more subcommittees to perform such duties as may be deemed necessary.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—222.5(231) Expenses of preparedness advisory committee voting members. The following may be considered necessary expenses for reimbursement of council members who are individuals with

disabilities or caregivers when incurred on behalf of council business and are subject to established state reimbursement rates:

1. Reimbursement for travel in a private car.
2. Actual lodging and meal expenses, including sales tax on lodging and meals.
3. Actual expense of public transportation.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—222.6(231) Council composition. A council's composition must include nine members with at least 50 percent of members being individuals with disabilities or caregivers.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code chapter 231.

[Filed ARC 9282C (Notice ARC 9018C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTER 223
DISABILITY SERVICES

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

441—223.1(231) Eligibility for LTSS disability services. To be eligible for disability services system funding, an individual will meet the following financial and needs-based eligibility criteria.

223.1(1) *Financial eligibility.*

a. An adult with disabilities will have an income equal to or less than 200 percent of the federal poverty level.

b. A family of a child with disabilities will have an income equal to or less than 200 percent of the federal poverty level.

c. A person who is eligible for federally funded services and other support will apply for such services and support.

d. Income will be verified using the best information available.

e. Financial eligibility will be reviewed on an annual basis and may be reviewed more often in response to increases or decreases in income.

f. An individual who is eligible for medical assistance must apply for and exhaust such funding for services and support prior to utilization of disability service system funding.

223.1(2) *Resource requirements.* There are no resource limits for the family of a child seeking children's disability services. An adult seeking disability services must have resources that are equal to or less than $2,000 in countable value for a single-person household or $3,000 in countable value for a multiperson household or follow the most recent federal supplemental security income guidelines.

a. The countable value of all countable resources, both liquid and nonliquid, shall be included in the eligibility determination, except as exempted in this subrule.

b. A transfer of property or other assets within five years of the time of application with the result of qualifying, or with the intent to qualify, for assistance may result in denial or discontinuation of funding.

c. The following resources are exempt:

(1) A homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.

(2) One automobile used for transportation.

(3) Tools of an actively pursued trade.

(4) General household furnishings and personal items.

(5) Burial account or trust limited in value as to that allowed in the medical assistance program.

(6) Cash surrender value of life insurance with a face value of less than $1,500 on any one person.

(7) Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

d. If an individual does not qualify for federally funded or state-funded services or other support but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources are also exempt from consideration in eligibility determination:

(1) A retirement account that is in the accumulation stage.

(2) A medical savings account.

(3) An assistive technology account.

(4) A burial account or trust limited in value as to that allowed in the medical assistance program.

223.1(3) *Needs-based eligibility.*

a. An individual must be a resident of Iowa, or, if the individual is a minor, the custodial parent must be a resident of Iowa.

b. An individual must have a disability and reside in or be at risk of residing in institutional settings due to the individual's disability.

c. The results of a standardized functional assessment must support the type and frequency of disability services identified in the individual's case plan. A functional assessment must be completed

within 60 days of application for services. The standardized functional assessment methodology will be developed by the department.
[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—223.2(231) Option for waiting lists for disability services. The department will maintain a waiting list of individuals denied access to the program due to lack of available funds. Waiting list information will include the date on which the individual was placed on the waiting list. If additional funds become available, the department will contact individuals on the list.
[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—223.3(231) Access standards. DAPs shall meet the following access standards.

223.3(1) *Support for community living.* The first appointment shall occur within 30 days of the completion of the functional assessment determining need for a home health aide, home and vehicle modification, respite, or supportive community living.

223.3(2) *Support for employment.* The initial referral shall take place within seven days of the completion of the functional assessment determining need for day habilitation, job development, supported employment, or prevocational services.

223.3(3) *Service coordination.* An individual shall receive service coordination within ten days of the initial request for such service.

223.3(4) *Service limitations.* The following limitations apply for an individual receiving disability services:

a. A service limit equal to that established for the home- and community-based services waiver for individuals with disabilities in the medical assistance program created in Iowa Code chapter 249A.

b. A provider reimbursement payment will not be less than that provided through the home- and community-based services waiver for individuals with disabilities in the medical assistance program created in Iowa Code chapter 249A.

223.3(5) *Additional access standards.* Additional minimum access standards for STSS and LTSS will be defined in the DAP's district plan and approved by the department.
[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—223.4(231) Appeal rights.

223.4(1) *Definitions.* For the purposes of this rule, the following definitions apply.

"Agency action" includes the whole or part of an agency rule or other statement of law or policy, order, decision, license, proceeding, investigation, sanction, relief, or the equivalent or a denial thereof, or a failure to act, or any other exercise of agency discretion or failure to do so, or the performance of any agency duty or the failure to do so.

"Appellant" means any person bringing an appeal under this chapter, including any person's authorized representative as defined in subrule 223.4(14).

"Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

"Reviewer" means the individual assigned by the department to review an appeal record and issue a written decision on behalf of the department. The department's reviewer will be screened from the underlying case and will not have prior knowledge of the facts that precipitated the appeal.

223.4(2) *Appeal.* A person that disagrees with the department's agency action related to an eligibility determination or denial of disability services may request an appeal within 120 calendar days of the date of the determination or denial.

a. The following actions may be appealed:

(1) The determination that eligibility criteria have not been met.
(2) The denial or limited authorization of a requested service, including the type or level of service.
(3) The decision to reduce, suspend, or terminate previously authorized services.
(4) The denial, in whole or in part, of payment for a service that was provided.
(5) The failure of the department to act within the required time frames.

b. Appeal requests submitted by regular mail are considered filed on the date postmarked on the envelope sent to the department or, when a postmarked envelope is not available, on the date the appeal is stamped received by the department. Appeal requests sent electronically are considered filed on the date on which the electronic submission was completed.

c. In computing any time period specified in this rule, the period:

(1) Excludes the day of the event that triggers the period;

(2) Includes every day of the time period (including Saturdays, Sundays, and holidays on which the department is closed); and

(3) Includes the last day of the period, but if the last day is a Saturday, Sunday, or legal holiday, the period continues until the end of the next day that is not a Saturday, Sunday, or legal holiday.

223.4(3) *Request.* The person may request an appeal using a form prescribed by the department and in a manner prescribed by the department.

223.4(4) *Acknowledgment of appeal.* The department will send an acknowledgment of receipt of the appeal to the parties-in-interest to the appeal.

223.4(5) *Acceptance or denial of appeal.* The department will determine with reasonable promptness whether the person is entitled to an appeal. If a request for an appeal is denied, the department will provide written notice of and the reasons for the denial. On or before the thirtieth calendar day following the denial of appeal, the party requesting the appeal may provide additional information related to the appeal and request reconsideration of the denial of the appeal.

223.4(6) *Documentation.* If an appeal request is granted, the appellant may submit a written statement, supported by relevant documentation, to establish all pertinent facts and circumstances. Documents shall be submitted to the department within 14 calendar days of the date the appeal is acknowledged. The department's reviewer may request additional documents or information from the appellant as needed to assist the department's evaluation of the appeal.

223.4(7) *Ex parte communication.* The department's reviewer, the director, and all parties to the appeal are bound by the rules against ex parte communication set forth in Iowa Code section 17A.17 and rule 441—7.9(17A).

223.4(8) *Withdrawal.* An appellant may withdraw a request for appeal at any time. Requests to withdraw an appeal will be granted.

223.4(9) *Department review.* The department's reviewer will review the appeal record and issue a written proposed decision to all parties within 30 calendar days. The written proposed decision will include the reviewer's findings of fact and rationale for the decision.

223.4(10) *Director's review.*

a. Time. Parties may appeal the proposed decision to the director. A request for director's review shall be in writing and postmarked or received within 14 calendar days of the date on which the proposed decision was issued. A request for director's review may be accompanied by a brief written summary of the arguments in favor of granting a director's review.

b. Granting or denial of review. The department has full discretion to grant or deny a request for director's review. In addition, the director may initiate review of a proposed decision on the director's own motion at any time on or before the thirtieth calendar day following the issuance of the proposed decision. When the department grants a request for director's review, the parties will be notified of the decision, and a copy of the request will be included with the notification.

c. Limited record. A director's review will be limited to the issues and information contained in the record reviewed by the reviewer who issued the proposed decision.

d. Oral arguments. Upon specific request, the director may, at the director's discretion, permit parties to present oral arguments with the parties' requests for director's review.

e. Decision issued. The director will issue a final decision within the timelines prescribed by federal or state law. For all appeals for which there is no federal or state timeliness standard, the director will issue a final decision on or before the ninetieth day from the date the director grants review.

223.4(11) *Final decisions.*

a. No appeal or denial of director review. If there is no timely appeal from or review of the proposed decision, the proposed decision will be considered the final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

b. Director decision issued. Any decision issued by the director after granting a director's review will be considered the final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

c. Written notice of final decision. The parties-in-interest will be provided written notice of the department's final decision. The department will also notify the appellant of the right to seek judicial review, where applicable.

223.4(12) *Interpreters.* The department will provide translation and interpretation services to parties-in-interest, if requested. When a party-in-interest is illiterate or semiliterate, the reviewer will advise the party-in-interest of the party-in-interest's rights.

223.4(13) *Persons living with disabilities.* Persons living with disabilities will be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act (as amended, effective December 31, 2023) and Section 504 of the Rehabilitation Act (as amended, effective October 1, 2016).

223.4(14) *Authorized representatives.*

a. Regulations. The provisions of this subrule only apply to the extent the standards expressed in this rule are not in conflict with other state or federal law.

b. Designation of authority. Legally recognized delegations of authority, such as guardianships, applicable designations of power of attorney, or similar designations, will be sufficient for a delegate to serve as authorized representative under this rule. A person that is not designated as a legally recognized delegation of authority but that otherwise seeks to act as an authorized representative for an individual in an appeal under this rule shall provide a written, signed designation of authority to the department with the request for appeal. The designation must provide the scope of the representation, applicable waivers for the release of confidential information, and any temporal or other limitations on the scope of representation. An authorized representative of a party-in-interest only represents the party-in-interest and has no independent right to appeal by virtue of the authorized representative's representation.

c. Appearance by attorney. Legal counsel appearing on behalf of any person in a proceeding under this rule shall enter an appropriate written appearance.

223.4(15) *Not contested cases.* Appeals brought under this chapter are not contested cases, appellants will not be granted a contested case hearing, and the provisions in 441—Chapter 2506 do not apply.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 231.23.

[Filed ARC 9282C (Notice ARC 9018C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

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

CHAPTER 224
AGING AND DISABILITY RESOURCE CENTERS

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

441—224.1(231) Definitions.

"Aging and disability resource center" or *"ADRC"* means a person-centered navigation and coordination system that blends and braids service delivery methods and funding to ensure supports and services contribute to a consumer's ability to remain at home and in the consumer's community. Supports and services are provided according to the individual's wants and needs.

"Aging and disability resource center member organization" or *"ADRC member organization"* means a local ADRC organization that provides ADRC information and assistance and person-centered functions at the local level.

"Information and assistance" means a service that provides an individual with current information on opportunities and services available within the individual's communities; identifies the problems and capacities of the individual; links the individual to the opportunities and services that are available; and, to the maximum extent practicable, ensures that the individual receives the services needed and is aware of the opportunities available by establishing adequate follow-up procedures.

"Medicaid administrative claiming" or *"MAC"* means federal matching funds under Medicaid are available for costs incurred by the state for administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid; support the provision of medical services covered under the state Medicaid plan when those activities are performed either directly by Iowa Medicaid or through contract or interagency agreement with another entity, such as a designated ADRC; or both.

"Navigator" means a person who provides ADRC information and assistance services, options counseling services, or both.

"Options counseling" means an interactive process whereby individuals receive guidance to make an informed choice about long-term supports. The process is directed by the individual and may include others whom the individual chooses or those who are legally authorized to represent the individual.

"System navigation" means in-person, online, and telephonic support for problem solving and navigation of the services and supports available. System navigators ensure individuals and families who encounter barriers in accessing services and support are able to navigate health care, social services, and legal systems.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—224.2(231) Department responsibilities.

224.2(1) Pursuant to Iowa Code section 231.64, the department will administer ADRCs.

224.2(2) The department's responsibilities are as follows:

a. Perform all duties mandated by federal and state law.

b. Designate ADRC member organizations and withdraw designation. If the department terminates its contract with an ADRC member organization for any reason, the entity is no longer designated by the department as an ADRC member organization.

c. Provide oversight of the ADRC to ensure compliance with federal and state law and applicable rules and regulations.

d. Monitor the operations and performance of the ADRC.

e. Develop and use data and indicators to measure and assess the performance of the ADRC to ensure quality services, fair treatment, cost-effectiveness, and consumer satisfaction.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—224.3(231) ADRC member organizations. The department designates entities as ADRC member organizations.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—224.4(231) ADRC member organization responsibilities.

224.4(1) An ADRC member organization will provide services to eligible populations in its service area via telephone, in-person, or electronic communications.

224.4(2) An ADRC member organization will be physically accessible and provide services in a private and confidential manner.

224.4(3) An ADRC member organization will ensure a system is available for answering and responding to messages received outside of the regular business hours.

224.4(4) An ADRC member organization will provide services to a person by using clear language and providing for reasonable accommodations.

224.4(5) An ADRC member organization will provide person-centered supports and navigation services according to the individual's personal preferences, identified needs, and unique capabilities to remain living at home and in the individual's community.

224.4(6) An ADRC member organization will identify itself as an ADRC. The ADRC's name may be the primary name or a subtitle to another name, but the designation of ADRC will be included in all advertising and outreach materials.

224.4(7) An ADRC member organization will adhere to the department's Medicaid ADRC federal financial participation (FFP) process for MAC. Participation in MAC for activities that facilitate access to, or are in support of, Iowa's Medicaid state plan are allowable. The ADRC will comply with the department-approved ADRC MAC methodologies.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—224.5(231) ADRC member organization staff requirements and background checks.

224.5(1) *Staffing.* The ADRC member organization will ensure adequate staffing levels to meet the needs of the service delivery area. Staff performing ADRC services will demonstrate competency and knowledge pertinent to the staff's areas of responsibility. Additionally, the ADRC will establish and maintain background check policies and procedures.

224.5(2) *Training and mandatory reporter status.* ADRC navigators are mandatory reporters pursuant to Iowa Code chapter 235B and will adhere to federal and state law and applicable rules for mandatory reporters.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—224.6(231) Services. The ADRC will provide information and assistance and options counseling as defined within the contract issued by the department.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—224.7(231) Grievances. The ADRC will implement a process for reviewing and resolving individual grievances.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—224.8(231) Reporting and records authority. The director is the principal officer of the state to administer ADRC data reporting. On behalf of the department, the ADRC shall report individual-level client data, information, and performance as required by the department. The ADRC shall also cooperate with any external review of its activities by the department or the federal government. The ADRC shall submit data according to the frequency, file layouts, format, and naming conventions prescribed by the department.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

441—224.9(231) Confidentiality. The ADRC shall not disclose records that contain personally identifiable information concerning an individual receiving services to entities outside the department without the individual's informed consent or as authorized or required by law.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 231.64.

[Filed ARC 9282C (Notice ARC 9018C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTER 225
AGING SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—225.1(231) Applicability. The rules set forth in the chapters under the jurisdiction of the department apply to all grants awarded to any recipient through the department and to any entities regulated by the department. Compliance with these rules is mandatory unless a waiver is granted in accordance with the procedures in 441—Chapter 2504.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—225.2(231) Definitions. The following definitions apply to 441—Chapters 225 through 229 unless otherwise specified.

225.2(1) *Definitions.*

"Administration on Aging" means the federal agency established to administer the provisions of the federal Act.

"Dietitian" or *"licensed dietitian"* means a person who maintains a license granted by the Iowa board of dietetics.

"Federal Act" means the Older Americans Act, 42 U.S.C. §3001 et seq., as amended to October 1, 2025, and all references herein are as amended to October 1, 2025.

"Plan of correction" means a plan developed by an area agency on aging and approved by the department that describes the actions the area agency on aging shall take to correct deficiencies arising from the agency's failure to perform and specifies the date by which those deficiencies shall be corrected.

"Title" means a specific title of the federal Act.

225.2(2) *Definitions adopted by reference.* The following terms have the same meaning as defined in the federal Act and 45 CFR 1321 as amended to October 1, 2025:

"Abuse"
"Access" or *"access services"*
"Area agency on aging"
"Area plan on aging"
"Elder abuse"
"Family caregiver"
"Greatest economic need"
"Greatest social need"
"In-home services"
"Legal assistance"
"Multipurpose senior center"
"Neglect"
"Planning and service area (PSA)"
"Service provider"
"State plan on aging"
"Tribal organization"

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—225.3(231) Aging network. Aging services are delivered through the aging network, which consists of:

1. The state unit on aging, 441—Chapter 226;
2. Area agencies on aging, 441—Chapter 227;
3. Service providers;
4. Office of the state long-term care ombudsman, 441—Chapter 230; and
5. Aging and disability resource centers, 441—Chapter 224.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—225.4(231) Conflict of interest.

225.4(1) Conflict of interest includes any action or failure to act made by the state unit on aging, an area agency on aging, a service provider, a contractor, or a legal representative that may be an actual or perceived conflict between official duties and personal interest. Conflict of interest exists when any action made for program purposes by any entity or individual holding an official position or performing duties:

a. Results in a situation that interferes with a program's or program employee's or representative's ability to provide objective information or act in the best interests of the individual.

b. Uses an official position for private gain (other than salary).

c. Gives preferential treatment to any entity, contractor, or individual or fails to act impartially in the conduct of official duties.

d. Impedes or adversely affects governmental efficiency or economy.

e. Engages in conduct that could adversely affect the confidence of the public in the integrity of the program initiatives.

f. Creates circumstances where it might reasonably be perceived that an entity's or individual's judgment could be influenced by the nature of the circumstances.

g. Uses any property of the individual giving care or the individual receiving care for personal use.

h. Leads to decisions that are or have the appearance of being contrary to duties of the aging network, the state plan, or 45 CFR 1321 as amended to October 1, 2025.

225.4(2) The state unit on aging will have policies and procedures in effect to avoid conflicts of interest in accordance with 45 CFR 1321 as amended to October 1, 2025.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 231.

[Filed ARC 9495C (Notice ARC 9375C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

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

CHAPTER 226
STATE UNIT ON AGING RESPONSIBILITIES

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—226.1(231) Designated state unit on aging. The department is designated as the sole state unit on aging in Iowa. The department will perform all state unit on aging duties in accordance with the federal Act; 45 CFR 1321 through 1324 as amended to October 1, 2025; and Iowa Code chapter 231.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.2(231) Policies and procedures. The department will develop and maintain policies and procedures in accordance with the federal Act; 45 CFR 1321 and 1324 as amended to October 1, 2025; and Iowa Code chapter 231.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.3(231) Public input. The state unit on aging will establish mechanisms and varied methods to obtain the views of older individuals, family caregivers, service providers, and the public on a periodic basis, with a focus on those in greatest economic need and greatest social need according to 45 CFR 1321 as amended to October 1, 2025.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.4(231) State plan on aging.

226.4(1) *Authority.* As the state unit on aging, the department will develop and administer a state plan on aging and any state plan amendments made pursuant to the federal Act; 45 CFR Parts 1321 and 1324 as amended to October 1, 2025; and Iowa Code chapter 231.

226.4(2) *Multiyear state plan on aging.* The department will develop and submit for approval a two-, three-, or four-year state plan on aging in compliance with the federal Act; 45 CFR 1321 and 1324 as amended to October 1, 2025; Iowa Code chapter 231; and the procedures, instructions, and guidance issued by the federal Administration on Aging.

226.4(3) *State plan amendment.* The department may, in its discretion, develop and submit to the federal Administration on Aging an amendment to the state plan on aging at any time. Each amendment will be processed pursuant to 45 CFR 1321.31 as follows:

a. Amendments requiring approval by the Assistant Secretary for Aging must follow the process outlined in subrule 226.4(4).

b. Amendments requiring notice only are not subject to subrule 226.4(4) unless otherwise required by law.

226.4(4) *State plan on aging and state plan amendment requiring approval review process.* Once the department develops the state plan on aging or state plan amendment requiring prior approval, the department will comply with the following chronological review and comment process:

a. The department will hold at least one public hearing on the proposed state plan or state plan amendment; and

b. The department will submit the state plan or state plan amendment to the council on health and human services for consideration. The council will make recommendations on the state plan or state plan amendment after reviewing the plan and public comments; and

c. The department will submit a state plan or state plan amendment to the governor or governor's designee for approval and signature; and

d. The department will submit a state plan or state plan amendment approved by the governor to the federal Administration on Aging for approval at least 45 days before the effective date of the state plan or state plan amendment.

226.4(5) *State plan on aging or state plan amendment not approved.* If a state plan or state plan amendment is not approved by the governor or governor's designee or the federal Administration on Aging, the department may, in its discretion, table or revise the proposed state plan or state plan

amendment. If the department revises the proposed state plan or state plan amendment, the department will follow the comment and approval process outlined in subrule 226.4(4).

226.4(6) *Technical changes to state plan on aging.* The department or the governor may, at either party's discretion, make technical corrections to a submitted state plan or state plan amendment prior to approving it.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25; **ARC 0776D**, IAB 11/25/26, effective 1/1/27]

441—226.5(231) Designation of and changes to PSAs. The department will divide the state into distinct PSAs in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; and Iowa Code chapter 231.

226.5(1) Notice of changes to PSAs will be provided in accordance with 441—Chapter 16.

226.5(2) Appeals to designation of and changes to PSAs.

a. Appeals to the department's designation of PSAs may be brought forth by applicants seeking to change existing PSA designation.

b. Appeals will be provided in accordance with 441—Chapter 2506. Iowa Code section 17A.19 does not apply to these appeals. Applicants whose appeal rights have been exhausted may appeal that decision to the federal Departmental Appeals Board (DAB) in accordance with the federal Act and with the procedures set forth in 45 CFR Part 16 as amended to October 1, 2025.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—226.6(231) Designating area agencies on aging. The department will designate an area agency on aging for each PSA in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; and Iowa Code chapter 231. Upon designation, an area agency on aging is considered an instrumentality of the state and will adhere to all state and federal mandates applicable to an instrumentality of the state.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.7(231) Withdrawal of designation of area agency on aging. The department will withdraw an area agency on aging's designation as an area agency when the department determines that the area agency on aging does not meet the requirements of the federal Act, regulations, Iowa Code, Iowa Administrative Code, terms and conditions of grant awards, or department policies and procedures. Notice of withdrawal will be provided in accordance with 441—Chapter 16.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.8(231) Appeals to withdrawal of area agency on aging designation.

226.8(1) An area agency on aging may appeal the department's action or proceeding to withdraw the designation of an area agency on aging. Appeals will be provided in accordance with 441—Chapter 2506. Iowa Code section 17A.19 does not apply to these appeals.

226.8(2) An area agency on aging may appeal the department's decision to the federal DAB in accordance with the federal Act and with the procedures set forth in 45 CFR Part 16 as amended to October 1, 2025. The DAB may refer an appeal to its Alternative Dispute Resolution Division for mediation prior to making a decision on the appeal.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—226.9(231) Area plan on aging reviews and approvals. The department will review new, revised, or amended area plans on aging and may approve once any plan has been reviewed in accordance with the process in 441—Chapter 227.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.10(231) Intrastate funding formula. The department will develop an intrastate funding formula for distribution of funds received under the federal Act and state funds to organizations serving as designated area agencies on aging that complies with 45 CFR 1321.49 as amended to October 1, 2025.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.11(231) Evaluation and compliance. The department will monitor area agencies on aging to ensure quality performance and compliance as set forth in 45 CFR 1321 as amended to October 1, 2025.

226.11(1) *Correction of deficiencies.*

a. Remedies. The purpose of remedies is to ensure prompt action is taken by an area agency on aging to correct deficiencies arising from failure to perform as identified by this rule. The department will determine the remedies to be applied to the area agency on aging for failure to perform.

b. Number of remedies. The department may apply one or more remedies for each deficiency constituting failure to perform or for all deficiencies constituting failure to perform.

c. Notification requirements. The department will give the area agency on aging written notice of the remedy in accordance with 441—Chapter 16. The written notice of remedy will include the following:

(1) The nature of the failure to perform.

(2) The remedy imposed.

(3) The effective date of the remedy.

(4) The right to appeal the determination leading to the remedy.

d. Factors to be considered in selecting remedies. In order to select the appropriate remedy, the department will determine the seriousness of the failure to perform by considering whether the area agency on aging's failure to perform:

(1) Is isolated.

(2) Constitutes a pattern.

(3) Is broad in scope.

(4) Creates a financial burden for the department, other area agencies on aging, or the aging network.

(5) Creates an administrative burden for the department, other area agencies on aging, or the aging network.

226.11(2) *Available remedies.* The department may select one or more of the following remedies with reference to a cited failure to perform. In selecting an appropriate remedy, the department may also consider the area agency on aging's prior history of failure to perform in general and specifically with reference to the cited failure to perform.

a. Directed in-service training. The department may require the staff of an area agency on aging to attend an in-service training program. The area agency on aging is responsible for the payment for the directed in-service training.

b. Department monitoring. The department may require an area agency on aging to receive increased monitoring by the department. The frequency and duration of the monitoring is within the discretion of the department.

c. Directed plan of correction. The department may develop a plan of correction and require an area agency on aging to take action within specified time frames.

d. Mandatory plan of correction. The department may require an area agency on aging to develop a mandatory plan of correction for approval by the department within specified time frames pursuant to subrule 226.11(2).

e. Reduction of funding. The department may reduce the amount of funding distributed.

f. Investigative audit. The department may require an area agency on aging to receive an investigative audit. The area agency on aging is responsible for the payment for this investigative audit.

g. Conditional approval. The department may conditionally approve area plans and amendments with required corrections to be made by the area agency on aging within no more than 90 days. If the plan is not approved, the department may withdraw designation as specified in rule 441—226.7(231).

h. Other remedies. The department may also impose other remedies, as appropriate.

i. Withdrawal of designation. The department may withdraw a designation of an area agency on aging pursuant to rule 441—226.7(231).

226.11(3) *Duration of remedies.* Remedies will continue until the area agency on aging has achieved substantial compliance as determined by the department or the designation as an area agency on aging is withdrawn.

226.11(4) *Appeal of a determination of failure to perform.*

a. An area agency on aging may appeal the department's determination of a failure to perform that leads to a remedy citation. Appeals will be provided in accordance with 441—Chapter 2506. Iowa Code section 17A.19 does not apply to these appeals.

b. An area agency on aging may not appeal the choice of remedy, including the factors considered by the department in choosing the remedy.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—226.12(231) Data management. The director is the principal officer of the state to administer data reporting. The department will maintain data on all individuals served. The department will develop policy and procedures for data management and confidentiality in accordance with 45 CFR 1321 as amended to October 1, 2025.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.13(231) State agency Title III and Title VI coordination responsibilities. The department will coordinate efforts with Title III and Title VI programs, including area agencies on aging and service providers, to ensure outreach is provided to tribal elders and family caregivers regarding services for which they may be eligible under Title III or Title VI or both in accordance with 45 CFR 1321.53 as amended to October 1, 2025.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.14(231) Emergency and disaster requirements.

226.14(1) *Emergency planning.* The department will:

a. Establish emergency plans as set forth in Section 307(a)(28) of the federal Act.

b. Coordinate with area agencies on aging, service providers, and local emergency management.

c. Coordinate efforts among area agencies on aging and Title VI programs in emergency and disaster preparedness planning, response, and recovery. The department will communicate with the relevant Title VI program director(s) as set forth in 45 CFR 1322 as amended to October 1, 2025, to specify how the department and the area agencies on aging will communicate and coordinate with Title VI programs regarding emergency and disaster preparedness planning, response, and recovery.

226.14(2) *Use of Title III funds to address disasters.*

a. The department in its discretion may use Title III funds without regard to its approved intrastate funding formation or funds distribution plan during presidential declared major disaster declarations under the Stafford Act (42 U.S.C. 5121 through 5207 as amended to October 1, 2025) when Title III services as defined in 441—Chapter 228 are impacted by the declaration.

b. When implementing this authority, the department may set aside funds, up to 5 percent of the department's total Title III allocations, if specified as being allowed to be withheld for the purpose in the department's approved intrastate funding formula or funds distribution plan, or with prior approval from the Assistant Secretary for Aging.

c. Set-aside funds that are awarded under this provision must comply with the requirements in 45 CFR 1321.101 as amended to October 1, 2025.

d. If the state or an Indian tribe requests and receives a major disaster declaration under the Stafford Act (42 U.S.C. 5121 through 5207 as amended to October 1, 2025), the department may use disaster relief flexibilities under Title III as set forth in 45 CFR 1321.101 as amended to October 1, 2025, to provide disaster relief services for areas of the state where the specific major disaster declaration is authorized and where older adults and family caregivers are affected.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.15(231) Prevention of elder abuse, neglect, and exploitation. In accordance with Title VII, Chapter 3, of the federal Act, the department will develop, strengthen, and carry out programs for the prevention of, detection of, assessment of, treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation. All programs using Title VII, Chapter 3, funds will meet requirements as set forth in the federal Act and guidance as set forth by the Assistant Secretary for Aging.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—226.16(231) State legal assistance development program. The department will designate a state legal assistance developer to ensure the provision and monitoring of legal assistance, advice, and technical assistance delivery to older individuals and other service providers. The legal assistance developer

activities will be contained in the state plan in accordance with the federal Act; 45 CFR 1324 as amended to October 1, 2025; and department policies and procedures. The state legal assistance developer may provide technical assistance to individuals when other legal assistance is not available.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 231.

[Filed ARC 9495C (Notice ARC 9375C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

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

[Filed ARC 0776D (Notice ARC 0619D, IAB 9/30/26), IAB 11/25/26, effective 1/1/27]

CHAPTER 227
AREA AGENCY ON AGING RESPONSIBILITIES

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—227.1(231) Area agency on aging responsibilities. Each area agency on aging will be the lead on all aging issues on behalf of all older individuals and caregivers in each PSA in accordance with the federal Act; 45 CFR 1321 through 1324 as amended to October 1, 2025; Iowa Code chapter 231; and policies and procedures defined by the department. Each area agency on aging is designated by the department as an aging and disability resource center as defined in rule 441—224.1(225A) and subject to the requirements therein.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.2(231) Board of directors. Each area agency on aging will have a board of directors in accordance with 45 CFR 1321 as amended to October 1, 2025; articles of incorporation; and bylaws. Pursuant to Iowa Code section 231.23, the area agency on aging will use the procedures defined by the department for selecting members of the area agency on aging's board of directors. The selection procedure will be incorporated into the bylaws of the board of directors.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.3(231) Staffing. Each area agency on aging will ensure adequate staffing levels to meet the needs of the PSA and the approved area plan. Each area agency on aging must notify the department of changes in management-level staff within seven calendar days. Staff performing area agency on aging functions and services will demonstrate competency and knowledge pertinent to the staff's areas of responsibility and include the following.

227.3(1) *Director.* Each area agency on aging's board of directors will name a qualified director and may employ other staff as necessary to manage and monitor the area plan.

227.3(2) *Fiscal.* Each area agency on aging will have adequate staff or contractors to perform duties to manage and monitor the fiscal responsibilities of an area agency on aging.

227.3(3) *Elder abuse prevention and awareness.* Staff and contractors completing elder abuse prevention and awareness activities must complete dependent adult mandatory reporter training requirements and any mandatory trainings from the department.

227.3(4) *Case management.* Staff and contractors completing case management activities must complete dependent adult mandatory reporter training requirements and any mandatory trainings from the department.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.4(231) Conflicts of interest. Each area agency on aging will have policies and procedures regarding conflicts of interest at organizational and individual levels in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; and department policies and procedures.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.5(231) Policies and procedures. Each area agency on aging will develop and maintain policies and procedures in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; and requirements set forth by the department. All manuals, guidelines, and standards referred to by these rules will be maintained by the area agency on aging and available for public inspection and departmental monitoring.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.6(231) Public participation.

227.6(1) *Advisory council.* Each area agency on aging will establish an advisory council. The council shall carry out advisory functions that further the area agency on aging's mission of developing and coordinating community-based systems of services for all older individuals and family and older relative caregivers specific to each PSA.

a. Composition of council. The council shall include individuals and representatives of community organizations from or serving the PSA who will help to enhance the leadership role of the area agency on aging in developing community-based systems of services prioritizing those in greatest economic need and greatest social need. The advisory council shall be made up of:

(1) More than 50 percent older individuals, including minority individuals who are participants or who are eligible to participate in programs under this rule, with efforts to include individuals identified as in greatest economic need and individuals identified as in greatest social need in 45 CFR 1321.65(b)(2) as amended to October 1, 2025;

(2) Representatives of older individuals;

(3) Family caregivers, which may include older relative caregivers;

(4) Representatives of health care provider organizations, including providers of veterans' health care (if appropriate);

(5) Representatives of service providers, which may include legal assistance, nutrition, evidence-based disease prevention and health promotion, caregiver, long-term care ombudsman, and other service providers;

(6) Persons with leadership experience in the private and voluntary sectors;

(7) Local elected officials;

(8) The general public; and

(9) As available:

1. Representatives from Indian tribes, pueblos, or tribal aging programs; and

2. Older relative caregivers, including kin and grandparent caregivers of children or adults aged 18 to 59 with a disability.

b. Conflicts of interest. Pursuant to 45 CFR 1321 as amended to October 1, 2025, the advisory council shall not operate as a board of directors for the area agency on aging. Individuals may not serve on both the advisory council and the board of directors for the same entity.

227.6(2) *Public input.* Each area agency will have mechanisms and varied methods to obtain periodic views of older individuals, caregivers, service providers, and the public with a focus on those in greatest economic need and greatest social need. Additionally, the views of participants will be obtained about the services participants receive, which will be used to improve services.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.7(231) Advocacy. Each area agency on aging will serve as the public advocate for the development and enhancement of comprehensive and coordinated community-based systems of services in each community throughout and specific to each PSA. Each area agency on aging will carry out this responsibility in accordance with 45 CFR 1321 as amended to October 1, 2025. Advocacy requirements shall not supersede a prohibition contained in the federal appropriation on the use of federal funds to lobby the Congress or the lobbying provision applicable to private nonprofit agencies and organizations contained in OMB Circular A-122 as amended to October 1, 2025.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.8(231) Area plan on aging. Each area agency on aging will operate under an area plan on aging approved by the department.

227.8(1) *Multiyear area plan on aging.* Each area agency on aging will develop and administer a two-, three-, or four-year area plan on aging specific to each PSA. Each area agency on aging will develop and submit the area plan on aging to the department for approval following the form, format, policies, and procedures specified by the department and in accordance with 45 CFR 1321.9 and 1321.65 as amended to October 1, 2025.

a. Area plan on aging annual update. Each area agency on aging will provide an annual update to its multiyear area plan on aging according to department policies, procedures, and instructions.

b. Area plan on aging amendments. Each area agency on aging will amend the approved area plan on aging and submit it to the department for approval when requested by the department or when necessary, according to 45 CFR 1321 as amended to October 1, 2025.

227.8(2) *Advisory council review and comment.* Each area agency on aging will submit any new area plan on aging, annual updates, or amendments for review and comment to the advisory council before the new plan, annual update, or amendment is sent to the department for approval.

227.8(3) *Public input.* Each area agency on aging will obtain public input in accordance with 45 CFR 1321.65 as amended to October 1, 2025. Each area agency on aging will:

a. Provide a minimum time period of at least 30 calendar days, unless a waiver is provided by the department during an emergency or when a time-sensitive action is otherwise necessary, for public review and comment on a new multiyear area plan on aging and area plan aging amendments;

b. Hold at least one public hearing on the area plan on aging and area plan amendments.

(1) The public hearing(s) will be held prior to submission of the area plan on aging or amendment(s) at a time that permits older individuals, public officials, and other interested parties reasonable opportunity to participate.

(2) The hearing(s) will be conducted in a barrier-free, fully accessible manner virtually or in person or both.

(3) The public hearing agenda and associated documents will be accessible and available to the public prior to the hearing.

1. Direct service waiver requests will be listed as a separate agenda item.
2. Priority services will be listed as a separate agenda item.

(4) Each area agency on aging will provide notice of the hearing in accordance with Iowa Code section 21.4(1) and by sending notice to all known groups of older individuals, PSA public officials, and other interested parties. The notice will be issued 30 days prior to the public hearing and include the time, date, and location of the public hearing. Each area agency on aging will comply with any applicable state or federal laws and regulations governing public hearing processes and procedures.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.9(231) Title III and Title VI coordination. For an area agency on aging where Title VI programs exist within the area agency on aging's PSA, the area agency on aging's policies and procedures, developed in coordination with the relevant Title VI program director(s), as set forth in 45 CFR 1322.13(a) as amended to October 1, 2025, must explain how the area agency on aging's network, including service providers, will coordinate with Title VI programs to ensure compliance with Section 306(a)(11)(B) of the federal Act (42 U.S.C. 3026(a)(11)(B) as amended to October 1, 2025).

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.10(231) Fiscal responsibilities.

227.10(1) *Expenditure of state and federal funds.* Each area agency on aging will adhere to the policies and procedures related to expenditure of state and federal funds developed in accordance with the federal Act; 45 CFR 1321 through 1324, 45 CFR 75, and 2 CFR 200, all as amended to October 1, 2025; Iowa Code chapter 231; and department policies and procedures.

227.10(2) *Contracts and commercial relationships.* A contract or agreement between an area agency on aging and an outside entity will not restrict the area agency on aging from contracting with other entities that provide similar services. All contracts and commercial relationships must avoid conflicts of interest as detailed in rule 441—225.3(231).

Notwithstanding the foregoing, 45 CFR Part 1321 as amended to October 1, 2025, and guidance from the federal Administration for Community Living govern operational and maintenance contracts. Such contracts do not require per-event state unit on aging approval beyond area plan budgeting. Each area agency on aging will maintain a file of all current contracts and contracts up to three years. These files will be made available for monitoring and assessment by the department. For the purposes of this subrule, "operational and maintenance contracts" are contracts with for-profit vendors for items including but not limited to building maintenance; heating, ventilation, and air conditioning (HVAC); information technology (IT) support; fleet repair; janitorial services; and utilities.

227.10(3) *Program income.* Funds collected and qualifying as program income must be handled in accordance with 45 CFR 1321.9(c)(2) as amended to October 1, 2025.

227.10(4) *Cost sharing.* Area agencies on aging may apply for a waiver using the department's processes to implement cost sharing for allowable services as part of the area plan on aging approval process consistent with 45 CFR 1321 as amended to October 1, 2025. Final approval of a cost sharing plan for each area agency on aging will be at the discretion of the department. If an area agency on aging has been approved by the department to implement cost sharing with consumers, each area agency on aging will follow the regulations of 45 CFR 1321 as amended to October 1, 2025. No eligible individual or family caregiver shall be denied service because the individual or family caregiver will not or cannot contribute to the cost of the service.

227.10(5) *Private pay.* Each area agency on aging or service provider may implement private pay programs in accordance with 45 CFR 1321 as amended to October 1, 2025, and department processes.

227.10(6) *Sectarian use.* Sectarian instruction or religious worship shall not be provided using funds received under the federal Act.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25; **ARC 0776D**, IAB 11/25/26, effective 1/1/27]

441—227.11(231) Compliance monitoring. Each area agency on aging will develop and implement procedures to monitor the programmatic and fiscal requirements of all programs, service providers and activities. Each area agency on aging will implement procedures to correct deficiencies in programmatic and fiscal performance of all programs, service providers and activities. Each area agency on aging will implement appropriate processes to monitor contracted entities determined to be subrecipients of the area agency on aging's federal funds.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.12(231) Quality performance. Each area agency on aging will develop and implement procedures in accordance with 45 CFR 1321 as amended to October 1, 2025, to evaluate and, when necessary, improve the quality and effectiveness of services provided directly by agency staff or contracted service providers.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.13(231) Data collection, sharing, and confidentiality.

227.13(1) *Data collection.* All data collected as a result of an organization's designation as an area agency on aging is owned and governed by the department's policies and procedures.

227.13(2) *Data protection.* Each area agency on aging will use appropriate administrative, technical and physical safeguards to protect the confidentiality, integrity and availability of data collected. Each area agency on aging will ensure that staff take appropriate confidentiality trainings and will provide documentation of completed trainings when requested by the department.

227.13(3) *Confidentiality.* Each area agency on aging will implement procedures to ensure confidentiality in compliance with 45 CFR 1321 as amended to October 1, 2025, and 441—Chapter 2505.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—227.14(231) Reporting. Each area agency on aging will submit consumer, service, program, and financial reports in accordance with department policies and procedures and with federal and state reporting requirements. Each area agency on aging will:

227.14(1) Complete client assessment and data collection, at a minimum, once each fiscal year per 45 CFR 1321 as amended to October 1, 2025.

227.14(2) Be solely responsible for obtaining and reporting necessary information from subgrantees, contractors and subcontractors.

227.14(3) Complete accurate program or financial reports by the established due dates, even if waiver is granted. Failure to do so may subject an area agency on aging to remedies provided in rule 441—226.5(231).

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.15(231) Emergency and disaster requirements.

227.15(1) *Emergency and disaster plans.* Each area agency on aging will establish emergency plans in accordance with 45 CFR 1321.97 as amended to October 1, 2025.

227.15(2) *Service coordination.* For continuity of services to individuals, each area agency on aging will coordinate with federal, local, and state emergency response agencies; service providers; relief organizations; local and state governments; and any other entities that have responsibility for disaster relief service delivery, as well as with tribal emergency management, as appropriate, to plan, respond, and recover from an emergency.

227.15(3) *Coordination with Title VI programs.* Area agencies on aging that have Title VI programs in operation within their PSA will have policies and procedures, developed in communication with the relevant Title VI program director(s) as set forth in 45 CFR 1322 as amended to October 1, 2025, in place for communication and coordination methods with Title VI programs regarding emergency and disaster preparedness planning, response, and recovery.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.16(231) Direct service provisions.

227.16(1) An area agency on aging will not provide a direct service as defined in 45 CFR 1321 as amended to October 1, 2025, except as allowed by the department pursuant to the requirements identified in the federal Act and 45 CFR 1321 as amended to October 1, 2025. The department in its judgment may allow an area agency on aging to provide any service directly when the area agency on aging demonstrates in its direct service request that:

a. Direct provision of service is necessary to ensure an adequate supply of the service and no potential provider was identified during the public hearing process; or

b. The proposed service will be of comparable quality in the view of the area agency on aging advisory council and will meet or exceed service standards developed by the area agency on aging; or

c. Each area agency on aging can provide a service of equal quality at lower cost than another provider.

227.16(2) The department may waive the conditions for direct service provision for case management, information and assistance services, and outreach services per 45 CFR 1321 as amended to October 1, 2025.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—227.17(231) Grievance. Each area agency on aging will implement grievance procedures in compliance with 45 CFR 1321 as amended to October 1, 2025. Those grievance procedures shall contain at least the following procedures for resolution:

1. Acknowledgment of grievance.
2. Process for attempting to informally resolve dispute.
3. Notification of the outcome of the grievance.
4. Opportunity to submit the grievance to the department.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 231.

[Filed ARC 9495C (Notice ARC 9375C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

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

[Filed ARC 0776D (Notice ARC 0619D, IAB 9/30/26), IAB 11/25/26, effective 1/1/27]

CHAPTER 228
DELIVERY OF AGING SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—228.1(231) Aging service delivery.

228.1(1) The federal Act authorizes grants to states to deliver a range of services through the area agencies on aging that include:

a. Supportive services and senior centers (Title III, Part B).

b. Nutrition services (Title III, Part C).

c. Evidence-based disease prevention and health promotion services (Title III, Part D).

d. Family caregiver support services (Title III, Part E).

e. Vulnerable elder rights protection activities (Title VII).

f. Programs for prevention of elder abuse, neglect, and exploitation (Title VII, Chapter 3).

g. State legal assistance development program as described in 441—Chapter 226 (Title VII, Chapter 4).

228.1(2) The department in its discretion may include additional services to meet the needs of individuals eligible for services under the federal Act. All services will be planned, approved, offered, monitored and evaluated in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; department policies and procedures; and area agency on aging policies and procedures.

228.1(3) Each area agency on aging will identify in its area plan on aging the services to be provided in the PSA as defined in 441—Chapters 226 and 227. The department in its discretion may identify the mandatory services that an area agency on aging will include in its area plan on aging.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.2(231) Eligibility. Older individuals and informal caregivers are eligible for Supporting Older Americans Act services.

228.2(1) *General eligibility.* Eligibility requirements for services as set forth in Title III of the federal Act and 45 CFR 1321 as amended to October 1, 2025, are as follows.

a. Older individual. An older individual is a person aged 60 or older.

b. Caregivers of older individuals. A family member, or another individual, who is aged 18 or older and is an informal provider of in-home and community care to:

(1) An older individual or

(2) A person of any age with Alzheimer's disease or a disease or related disorder with neurological and organic brain dysfunction as defined in the federal Act.

c. Older relative caregivers. An individual who is aged 55 or older and lives with, is the informal provider of in-home and community care to, and is the primary caregiver for a child or an individual with a disability.

(1) In the case of an older relative caregiver for a child, the older relative caregiver:

1. Is the grandparent, step-grandparent, or other older relative (other than the parent) by blood, marriage, or adoption of the child;

2. Is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregivers of the child; and

3. Has a legal relationship to the child, such as legal custody, adoption, or guardianship, or is raising the child informally.

(2) In the case of an older relative caregiver for an individual with a disability, the older relative caregiver is the parent, grandparent, step-grandparent, or other older relative by blood, marriage, or adoption of the individual with a disability.

228.2(2) *Nutrition services.* Eligibility for nutrition services as set forth in Title III, Part C, of the federal Act includes older individuals and their spouses regardless of age, volunteers during meal hours, and individuals with disabilities who are not older individuals but who live with an older individual or reside in housing facilities occupied primarily by older individuals and at which congregate nutrition services are provided.

228.2(3) *Elder abuse prevention and awareness.* An older individual is eligible for elder abuse prevention and awareness activities if the older individual has experienced elder abuse or neglect or is at risk for elder abuse or neglect. The older individual cannot be a current resident in a "nursing facility" as defined in Iowa Code section 135C.1(15).
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.3(231) Supportive services and senior centers.

228.3(1) *Authorized services.* Supportive services are access services, in-home supportive services, multipurpose senior centers, and legal services as set forth in the federal Act and 45 CFR 1321.85 as amended to October 1, 2025. Specific supportive services that may be offered in Iowa are adult day, assisted transportation, case management, chore, homemaker, information and assistance, legal assistance, outreach, personal care, transportation, and other supportive services identified by the department.

228.3(2) *Priority services.* In accordance with the federal Act and 45 CFR 1321 as amended to October 1, 2025, the department will identify and categorize specific Title III-B supportive services to be considered priority access services, in-home services, or a legal assistance service with a specified minimum percentage of Title III-B supportive services funds, less administrative costs, to be expended on priority services. An area agency on aging may request a waiver to the specified minimum percentage of Title III-B supportive services funds to be expended on the Title III-B priority services.

228.3(3) *Legal assistance.* Legal assistance providers shall provide effective administrative and judicial representation to older individuals and demonstrate expertise in areas of law that are given priority in the federal Act for non-fee-generating issues affecting older individuals with greatest economic or social needs, including income and public entitlement benefits, health care, long-term care, nutrition, consumer law, housing, utilities, protective services, abuse, neglect, age discrimination, and defense of guardianship.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.4(231) Nutrition services.

228.4(1) *Authorized services.* Nutrition services are home-delivered nutrition, congregate nutrition, nutrition education, nutrition counseling and other nutrition services.

228.4(2) *Nutrition project.* Nutrition project means congregate and home-delivered meals provided five or more days per week in a PSA by a qualified nutrition service provider under the state plan or area plan. Nutrition education, nutrition counseling, and other nutrition services are provided based on individual and community need and in coordination with other nutrition services available in the community.

228.4(3) *Licensed dietitian.* Each area agency on aging will utilize the services of a licensed dietitian to provide technical assistance in nutrition program management and to ensure that the nutrition project provides meals that comply with the nutrition guidelines outlined in the federal Act and further defined by the department.

228.4(4) *Food safety.* Nutrition service providers shall comply with all applicable state and local food and consumer safety and food establishment licensing, operating and inspection requirements. The occurrence or suspected occurrence of a foodborne illness by congregate nutrition or home-delivered nutrition services should be reported to the department within 24 hours.

228.4(5) *Ineligible individuals.* An individual who is not eligible for nutrition services may receive a meal by paying the full cost of the meal, including all programmatic and administrative costs, if the ineligible individual's receipt of the meal does not deprive an eligible participant of a meal.

228.4(6) *Nutrition education.* Nutrition education shall be offered in accordance with the federal Act and under the supervision of a licensed dietitian. Nutrition education shall be offered to all nutrition services consumers on a monthly basis, and recipients of home-delivered meals shall be offered nutrition education pertaining to safe food handling of the delivered meals twice annually.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.5(231) Evidence-based disease prevention and health promotion services. Evidence-based disease prevention and health promotion are provided in accordance with the federal Act and 45 CFR 1321 as amended to October 1, 2025.
[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.6(231) Family caregiver support services.

228.6(1) *Authorized services.* Family caregiver support services include information and service assistance, case management, counseling and training, support groups, respite, supplemental services, and other caregiver services as identified by the department.

228.6(2) *Supplemental services.* Supplemental services may be provided to family caregivers on a limited basis to complement the care provided by family caregivers. The department will define a maximum percentage to be expended on supplemental services.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.7(231) Prevention of elder abuse, neglect, and exploitation. Area agencies on aging will directly provide older adult abuse prevention and awareness activities and coordinate assessment services for older individuals experiencing or at risk for experiencing abuse, neglect, or exploitation.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.8(231) Service prioritization. In the event that an area agency on aging or service provider is unable to provide service to eligible individuals in need of assistance and needs to implement a wait list, the area agency on aging will prioritize service delivery to eligible individuals with greatest social need, eligible individuals with greatest economic need, and those at risk for institutional placement in accordance with the federal Act, state plan, area plans, and department policies and procedures.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.9(231) Service wait lists, unmet needs, and other changes to service. The area agency on aging will assess, request, and obtain department approval for service wait lists, meal site closures, reduction in the number of meal site and home-delivered nutrition serving days, or opening or relocating nutrition projects prior to implementation in accordance with department policies and procedures. The request must include:

1. Reasons for the action, including an evaluation in a format prescribed by the department of the use of resources in meeting the needs of those in greatest social need and greatest economic need; and
2. Impact on eligible individuals, including identifying new service gaps or filling service gaps by county or PSA.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.10(231) Voluntary contributions. All eligible individuals will be provided an opportunity to make a voluntary, confidential contribution to the cost of the service. No eligible individual or family caregiver will be denied service because the individual or family caregiver will not or cannot contribute to the cost of the service. Area agencies on aging will follow the regulations on voluntary contributions found in 45 CFR 1321.9(c)(2)(x) as amended to October 1, 2025.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.11(231) Membership fees. Payment of a membership fee cannot be required of eligible participants to access programs and services that receive or have received funds under the federal Act.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

441—228.12(231) Prohibition against means testing. No area agency on aging or its service provider may means test for service eligibility. Income from means-tested programs may not be used as a match for federal funds.

[**ARC 9495C**, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 231, subchapter VI.

[Filed ARC 9495C (Notice ARC 9375C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

CHAPTER 229
DATA COLLECTION

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

441—229.1(231) Authority. The director is the principal officer of the state to administer DAP aging and disability services data reporting. The department will collect and maintain data on all clients served in accordance with Iowa Code section 231.56.

229.1(1) *Submission of data.* Each DAP shall submit to the department the data regarding each individual the DAP serves.

a. DAPs shall submit data according to the frequency, file layouts, format, and naming conventions prescribed by the department.

b. When a DAP is notified by the department that the data are incomplete or are not compliant with the prescribed file layouts, format, or naming conventions, the DAP must correct the issue within 30 days of the notification.

229.1(2) *Data required.* The data to be submitted are as follows:

a. Individual client-level information, including a unique identifier, name, address, demographic information, service delivery information, referral information, and any other information as prescribed by the department.

b. The state identification number, when applicable.

c. Demographic information, including but not limited to date of birth, sex, ethnicity, marital status, education, residential living arrangement, current employment status, monthly income, income sources, type of insurance, insurance carrier, veteran status, guardianship status, legal status in the system, source of referral, and diagnosis code in the International Classification of Diseases (ICD) as amended to July 1, 2025.

d. Service information, including but not limited to the decision on services, date of decision, termination date and reason for termination, residence, approved service, service beginning dates, service ending dates, reason for terminating each service, approved units of services, unit rate for service, expenditure data, and provider data.

[**ARC 9282C**, IAB 5/14/25, effective 7/1/25]

This rule is intended to implement Iowa Code section 231.56.

[Filed ARC 9282C (Notice ARC 9018C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTER 230
LONG-TERM CARE OMBUDSMAN

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—230.1(231) Definitions.

"Certified volunteer" means a certified volunteer long-term care ombudsman as authorized under Iowa Code section 231.45. A certified volunteer is considered a representative of the office.

"Federal Act" means the federal Older Americans Act, 42 U.S.C. §3001 et seq., as amended to October 1, 2025.

"Office" means the office of the state long-term care ombudsman established pursuant to the federal Act and Iowa Code section 231.42.

"Ombudsman" means the state long-term care ombudsman appointed by the director.

"Representative of the office" means the same as defined in 45 CFR §1324.1 as amended to October 1, 2025.

[**ARC 9496C**, IAB 8/20/25, effective 10/1/25]

441—230.2(231) Interference. A representative of the office who is denied access to a resident or tenant in a long-term care facility, assisted living program, or elder group home or to medical and social records while in the course of conducting official duties pursuant to Iowa Code section 231.42 or whose work is interfered with during the course of an investigation shall report such denial or interference to the office, which will report the interference to the director.

[**ARC 9496C**, IAB 8/20/25, effective 10/1/25]

441—230.3(231) Monetary civil penalties—basis. The director, in consultation with the ombudsman, may impose a monetary civil penalty of not more than $1,500 on an officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home who intentionally prevents, interferes with, or attempts to impede the duties of the state, ombudsman, or representative of the office pursuant to Iowa Code section 231.42(8).

[**ARC 9496C**, IAB 8/20/25, effective 10/1/25]

441—230.4(231) Monetary civil penalties—notice of penalty. The office will notify the officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home in writing by certified mail of the intent to impose a civil penalty pursuant to 441—Chapter 16. The notice will include, at a minimum, the following information:

1. The nature of the interference and the date the action occurred.
2. The statutory basis for the penalty.
3. The amount of the penalty.
4. The date the penalty is due.
5. Instructions for responding to the notice, including information on the individual's right to appeal.

[**ARC 9496C**, IAB 8/20/25, effective 10/1/25]

441—230.5(231) Monetary civil penalties—appeals. An officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home who is assessed a monetary civil penalty for interference with the official duties of a long-term care ombudsman may appeal the penalty as set forth in 441—Chapter 2506.

[**ARC 9496C**, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—230.6(231) Certified volunteer long-term care ombudsman program.

230.6(1) Application. Any individual may apply to the office to become a certified volunteer.

a. Application forms. Application forms may be accessed on the department's website.

b. Submission of forms. Each applicant shall complete an application and submit it to the office at the address listed on the form.

230.6(2) Applicants shall not be accepted into the program if:

a. It is determined that the applicant has a conflict of interest as defined in the federal Act; or

b. The applicant has unfavorable references, which will include a criminal background check and abuse check.

230.6(3) Training. Prior to certification, applicants must successfully complete the required training as approved by the office. Successful completion means completion of all assignments and tasks during training, demonstration of proper techniques and skills, and an understanding of the role of the certified volunteer in the long-term care setting.

230.6(4) Approval for certification. Final approval for certification as a certified volunteer will be made by the office and will be subject to the applicant's successful completion of the required training. The office has the right to require that the applicant receive additional personal training prior to certification and has the right to deny certification to applicants not meeting the training criteria.

230.6(5) Certification.

a. Notification. A certified volunteer will be notified in writing within 14 days following the conclusion of the training program if certification has been continued or revoked.

b. Certification will initially be for one year, with recertification available following the certified volunteer's completion of a minimum of 18 hours of approved continuing education in the first year and completion of a progress review by the office.

230.6(6) Continuing education.

a. All certified volunteers shall complete a minimum of 18 hours of approved continuing education annually.

b. Certified volunteers are responsible for reporting continuing education hours to the office or designee within 30 days following the completion of the continuing education event.

230.6(7) Decertification.

a. Reasons for decertification. A certified volunteer may be decertified by the office for any of the following reasons:

(1) Falsification of information on the application;
(2) Breach of confidentiality;
(3) Acting as a certified volunteer without proper certification;
(4) Attending less than the required continuing education training;
(5) Voluntary termination;
(6) Unprofessional conduct;
(7) Failure to carry out the duties as assigned; or
(8) Actions that are found by the office to violate the rules or intent of the program.

b. Notice of decertification. The office will notify the certified volunteer and the facility in writing of a decertification pursuant to 441—Chapter 16.

c. Request for reconsideration. A request for reconsideration or reinstatement of certification may be made in writing to the office. The request must be filed within 14 days after receipt of the notice of revocation.

d. Response time. The office will investigate and consider the request and notify the requesting party and the facility of the decision within 30 days of receipt of the written request.

230.6(8) Duties. The certified volunteer shall assist the office or designee in carrying out the duties described in the federal Act.

[**ARC 9496C**, IAB 8/20/25, effective 10/1/25]

441—230.7(231) Managed care ombudsman services.

230.7(1) The office may provide advocacy and assistance to eligible recipients, or the families or legal representatives of such eligible recipients, of long-term services and supports provided through the Medicaid program who are receiving services in a long-term care facility or under one of the home- and community-based services waivers.

230.7(2) Representatives of the office providing an individual with assistance and advocacy services authorized under Iowa Code section 231.44 shall be provided access to the individual and to the individual's medical, social, and administrative records related to the provision of the long-term services

and supports to the individual, as authorized by the individual or the individual's legal representative, as necessary to carry out the duties specified by Iowa Code section 231.44.

230.7(3) The office and representatives of the office, when providing assistance and advocacy services under Iowa Code section 231.44, will be considered a health oversight agency as defined in 45 CFR §164.501 as amended to October 1, 2025, for the purposes of health oversight activities described in 45 CFR §164.512(d) as amended to October 1, 2025. Recipient information available to the office and representatives of the office under this subrule shall be limited to the recipient's protected health information as defined in 45 CFR §160.103 as amended to October 1, 2025, for the purpose of recipient case resolution.

[**ARC 9496C**, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code sections 231.41, 231.42, 231.44, and 231.45.

[Filed ARC 9496C (Notice ARC 9385C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

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

CHAPTER 231
OFFICE OF PUBLIC GUARDIAN

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—231.1(231E,633) Purpose. This chapter implements the office of public guardian as created in Iowa Code chapter 231E and establishes standards and procedures for the state office of public guardian and local offices of public guardian. It also establishes the qualifications of consumers eligible for services.
[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.2(231E,633) Definitions. Words and phrases used in this chapter are as defined in Iowa Code chapter 231E or 633 unless the context indicates otherwise. The following definitions also apply to this chapter:

"Evaluation" means a comprehensive, in-depth evaluation to identify an individual's current situation, ability to function, strengths, problems, and care needs in the following major functional areas: physical health, medical care utilization, activities of daily living, instrumental activities of daily living, mental and social functioning, financial resources, physical environment, and utilization of services and support.

"Fee" or *"fees"* means any costs assessed by the state office or a local office against a protected person or a client for public guardianship services.

"Guardian case manager" means an employee of the state office or a local office, or a contractor of a local office, who provides public guardianship services to protected persons or clients or who supervises employees, contractors, or volunteers who provide public guardianship services to protected persons or clients. "Guardian case manager" does not include employees or contractors whose responsibilities are strictly administrative in nature.

"Program" means the activities and services offered by the office of public guardian pursuant to Iowa Code chapter 231E.

"Record" means any information obtained by the state or local office in the performance of its duties.
[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.3(231E,633) Public guardian qualifications. All public guardians shall have graduated from an accredited four-year college or university or shall have an equivalent combination of education and full-time equivalent work experience working with older adults, people with disabilities, or people overcoming social, economic, psychological or health problems. All guardian case managers shall be certified by the Center for Guardianship Certification within 12 months of assuming duties as a guardian case manager. This certification shall be kept current while the person is serving as a guardian case manager.
[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.4(231E,633) Ethics and standards of practice. The state office adopts the National Guardianship Association Standards of Practice adopted in 2000, and revised in 2022, and as amended to October 1, 2025, as a statement of the best practices and the highest quality of practice for persons serving as guardians or conservators. The adoption of standards of practice in this document is not intended to amend or diminish the statutory scheme but rather to supplement and enhance the understanding of the statutory obligations to be met by public guardians when serving as a public guardian. Upon appointment to serve a protected person or client, the public guardian shall perform all duties imposed by the court or other entity having jurisdiction and imposed by applicable law and, as appropriate, shall utilize standards found in the National Guardianship Association Standards of Practice as amended to October 1, 2025. Representative payees will adhere to the standards of the Social Security Administration, as well as any service contracts or grants established by the department.
[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.5(231E,633) Staffing ratio. The state office or a local office will be responsible for no more than 40 protected persons per full-time equivalent guardian case manager at any one time. In the state office's sole discretion, the state office or a local office may exceed staffing ratios only under the following circumstances:

1. A priority situation exists as defined in subrule 231.7(2), and
2. Acceptance of case(s) will not adversely affect services to current protected persons or clients.

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.6(231E,633) Conflict of interest. A conflict of interest arises when the state office or a local office serving a protected person or client has any personal or departmental interest that is or may be perceived as self-serving or adverse to the position or best interest of the protected person or client. When assigning the state office or a local office, all reasonable efforts shall be made to avoid a conflict of interest or the appearance of a conflict of interest.

231.6(1) The assigned state office or local office shall not:

a. Provide direct services to the protected person or client receiving public guardianship services;

b. Enter into any transaction, take any action, or make any decision related to the protected person's or client's finances that would benefit the state office or a local office; any of the state office's or a local office's employees, volunteers, or contractors; or any relatives of any of the state office's or a local office's employees, volunteers, or contractors;

c. Employ friends or family to provide services to the protected person or client for a fee; or

d. Solicit or accept incentives from service providers.

231.6(2) The state office or a local office shall be independent from all service providers, thus ensuring that the public guardian remains free to challenge inappropriate or poorly delivered services and to advocate on behalf of the protected person or client.

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.7(231E,633) Individuals eligible for services. The office of public guardian will seek to restrict appointments to only those necessary. The state office or a local office will not accept an appointment based upon a voluntary petition unless that appointment is as a successor guardian or conservator and the court has, after notice and hearing, found by clear and convincing evidence that the protected person meets the legal standard for appointment of a guardian in Iowa Code section 633.552, the legal standard for appointment of a conservator in Iowa Code section 633.553, or both.

231.7(1) In order to qualify for services, an individual shall meet all of the following criteria:

a. Is a resident of the state of Iowa;

b. Is aged 18 or older or is at least 17 years and six months of age for appointment of a guardian or conservator on a standby basis for a minor approaching majority pursuant to Iowa Code section 633.567;

c. Does not have a suitable individual or appropriate entity willing and able to serve as guardian, conservator, or representative payee;

d. Is "incompetent" as defined in Iowa Code section 633.3(25) (for appointment of a guardian or conservator) or is incapable of managing social security or supplemental security income (SSI) payments as determined by the Social Security Administration (for representative payee);

e. Is an individual for whom guardianship, conservatorship, or representative payee services are the least restrictive means of meeting the individual's needs; and

f. A viable plan for improving the care and safety of the individual is possible.

231.7(2) The following cases shall be given priority:

a. Those involving abuse, neglect or exploitation that public guardianship services can address;

b. Those in which a critical medical decision must be made; or

c. Any situation that may cause serious or irreparable harm to the individual's mental or physical health or finances.

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.8(231E,633) Application and intake process—guardianship, conservatorship, and representative payee.

231.8(1) Any person may submit an application for services on behalf of an individual believed to be in need of public guardianship services. Applications are available on the department's website. Incomplete applications will not be considered. Communication with the state office or a local office or the submission of an application does not guarantee eligibility for public guardianship services and does not create any

type of fiduciary relationship between the state office and the individual on whose behalf the application is submitted.

231.8(2) The state office will make a determination regarding eligibility of the individual and acceptance or denial of the case based on a review of the completed application.

231.8(3) The state office will grant or deny an application for services as soon as practicable but, in any event, within 60 days of receipt of the application.

231.8(4) Failure of the state office to grant or deny an application within the specified time period may be deemed a denial of the application by the state office.

231.8(5) In the event that the state office or a local office does not have sufficient resources to accept new cases, the state office will place applications that are eligible for public guardianship services on a waiting list.

a. Cases will be taken off the waiting list in the order in which they were received.

b. Cases that meet the priority criteria outlined in subrule 231.7(2) will be moved to the top of the waiting list and will be taken off the waiting list in the order in which they were received.

231.8(6) The state office or a local office will only file a petition to be appointed as guardian or conservator of an eligible individual if there is no person or entity that has an interest in the welfare of the adult who could file the petition pursuant to Iowa Code section 633.556(1).

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.9(231E,633) Case records.

231.9(1) The state office or a local office will establish a case record for each protected person or client the state office or a local office is appointed to serve. At a minimum, the case record must contain demographic information, including:

a. Copies of the evaluations, medical records, and updates, if any;

b. A separate financial management folder containing an inventory, an individual financial management plan, a record of all financial transactions made on behalf of the protected person or client by the public guardian, copies of receipts for all expenditures made by the public guardian on behalf of the protected person or client, and copies of all other documents pertaining to the protected person or client's financial situation as required by the state office;

c. Itemized statements of costs incurred in the provision of services for which the public guardian received court-authorized reimbursement directly from the protected person or client's estate; and

d. Other information as required by the state office.

231.9(2) All case records maintained by the public guardian shall be confidential as provided in Iowa Code section 231E.4(6)*"g."*

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.10(231E,633) Confidentiality. Notwithstanding Iowa Code chapter 22, the following provisions shall apply to records obtained by public guardians in the course of their duties.

231.10(1) Unless otherwise provided by rule or law, records and information of the state office of public guardian are governed by 441—Chapter 2505.

231.10(2) Records and information obtained as part of an application for public guardianship services are confidential.

a. If more than one application for public guardianship services is submitted on behalf of the same individual, the state office may disclose the following information to the applicants:

(1) The date of any other application submitted on behalf of the individual;

(2) The name and contact information of the other applicant or applicants;

(3) The status of the other application or applications, including copies of any notices sent to the other applicant or applicants.

b. The state office or a local office may disclose the existence of an application and information contained in an application to family members, service providers, case managers, or others named in an application for public guardianship services in order to gather supplemental information necessary to determine eligibility for public guardianship services or to attempt to locate an individual for whom an application was submitted.

c. The state office may release records and information obtained as part of an application for public guardianship services to a local office of public guardian in anticipation of the local office providing public guardianship services to the individual.

231.10(3) Records and information about a protected person or client obtained or maintained for use by the state office or a local office of public guardian are confidential. Once appointed as an individual's guardian, conservator, or representative payee, the state office or a local office may, at the state office's or a local office's sole discretion, exercise the authority granted by the court or federal agency to obtain, disclose, or consent to the release of confidential records or information about the protected person or client if doing so is necessary and in the best interest of the protected person or client. The state office or a local office will obtain the written consent of the protected person or client or the person's or client's legal representative prior to obtaining or disclosing confidential records or information outside the scope of the state office's or a local office's authority. Disclosure of a record or information under this rule does not affect the confidential nature of the record.

231.10(4) Records and information may be redacted so that personally identifiable information is kept confidential.

231.10(5) The state office or a local office may enter into contracts or agreements with public or private entities in order to carry out the state office's or a local office's official duties. Information necessary to carry out these duties may be shared with these entities.

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—231.11(231E,633) Termination or limitation. Either a local office or the state office may seek the termination or limitation of a local office's duties under circumstances including:

1. Public guardianship services are no longer needed or do not benefit the protected person or client;
2. The protected person's or client's assets allow for hiring a paid guardianship or conservatorship service provider;
3. A conflict of interest or the appearance of a conflict of interest arises;
4. The state or a local office lacks adequate staff or financial resources;
5. The protected person or client moves outside the state or outside the local office's service area;
6. Public guardianship is no longer the last resort for assistance;
7. The contract between the state office and a local office is terminated by either party and there is no other local office that can be appointed as a successor;
8. Termination of the program by law; or
9. Other circumstances that indicate a need for termination or limitation.

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.12(231E,633) Service fees.

231.12(1) The state office and a local office shall be entitled to reasonable compensation for their public guardianship services as determined by using the following criteria:

a. Such compensation shall not exceed actual costs.

b. Collection of fees may be adjusted or waived based upon the ability of the protected person or client to pay, upon whether financial hardship to the protected person or client would result, or upon a finding that collection of such fees is not economically feasible.

c. The state office may collect a fee from the estate of a deceased consumer.

231.12(2) Fees for guardianship and conservatorship services provided by the state office will be assessed according to the following fee schedule:

Action or Responsibility	**Fee**
One-time case opening:	
Guardianship	$200
Conservatorship	$300
Guardian and conservatorship	$500
Monthly guardianship and/or conservatorship services.	

Action or Responsibility	Fee
Total value of liquid assets:	
$1,500 - $9,999	$100
$10,000 - $19,999	$125
$20,000 - $29,999	$150
$30,000 - $39,999	$175
$40,000 - $49,999	$200
$50,000 - $59,999	$225
$60,000 - $69,999	$250
$70,000 - $79,999	$275
$80,000 - $89,999	$300
$90,000 - $99,999	$325
$100,000 or above	$350

231.12(3) Fees for guardianship and conservatorship services provided by a local office will be assessed at the rates established by contract between the state office and a local office. Contracts between the state office and local offices are public records.

231.12(4) Fees for representative payee services will be as established by the federal governmental agency that appoints the representative payee.

231.12(5) Notwithstanding the foregoing, the state office or a local office may collect fees pursuant to court order for other actual, necessary and extraordinary services or expenses, including legal fees. Necessary and extraordinary services or expenses may include but are not limited to services or expenses related to:

a. Recovering real or personal property or funds belonging to the protected person,

b. Bringing or defending against a suit or claim on behalf of the protected person,

c. Challenging the actions or accounting of a prior fiduciary, or

d. Establishing a trust for the benefit of the protected person.

231.12(6) The state office or a local office may collect fees even when claims of creditors of the consumer may be compromised.

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

441—231.13(231E,633) Denial of services—appeal.

231.13(1) An application for services will be denied when it is determined by the state office that:

a. The application is incomplete;

b. The individual is not a resident of Iowa;

c. The individual is not aged 18 or older (or at least 17 and 6 months of age for appointment of a guardian or conservator on a standby basis for a minor approaching majority pursuant to Iowa Code section 633.567);

d. The individual has a suitable individual or appropriate entity willing and able to serve as guardian, conservator, or representative payee;

e. The individual has adequate financial resources available to compensate a professional guardian, conservator, or representative payee;

f. The individual is not incompetent as defined in Iowa Code section 633.3(25) (for appointment of a guardian or conservator);

g. The individual is not incapable of managing the individual's social security or SSI payments as determined by the Social Security Administration (for representative payee);

h. The individual is not an individual for whom guardianship, conservatorship, or representative payee services are the least restrictive means of meeting the individual's needs; or

i. A viable plan for improving the care and safety of the individual is not possible.

231.13(2) Notice of denial will be provided in accordance with 441—Chapter 16.

231.13(3) Applicants wishing to challenge a denial based on paragraph 231.13(1)*"f"* may file a petition pursuant to Iowa Code section 633.556 within 30 days of the date of the denial and give notice of the filing of the petition to the state office of public guardian.

231.13(4) Applicants wishing to challenge a denial for any other reason listed in subrule 231.13(1) may appeal in accordance with 441—Chapter 2506.

231.13(5) If the state office or a local office petitions to terminate services, a protected person or client may challenge that decision in the appropriate court or federal agency.

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—231.14(231E,633) Contesting the actions of a guardian, conservator, or representative payee.

231.14(1) Each local office shall develop a complaint procedure for the internal investigation and resolution of complaints. The complaint procedure shall be made available on the local office's website. The local office will provide a copy of the complaint procedure to each protected person and client.

231.14(2) If a complaint is not resolved by the local office to the satisfaction of the complainant, the complainant may express the complainant's concerns to the state office in writing or verbally.

231.14(3) The state office will advise the complainant that the complainant may also raise any concerns with the court or with the federal governmental agency with oversight of the representative payee.

[**ARC 9497C**, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapters 231E and 633.

[Filed ARC 9497C (Notice ARC 9380C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

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

CHAPTERS 232 to 299
Reserved

TITLE XVIII
BEHAVIORIAL HEALTH SERVICES

CHAPTER 300
DEFINITIONS

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

441—300.1(225A) Definitions.

"Access funds" means funding provided to a behavioral health safety net provider by a behavioral health administrative services organization to support enhanced service delivery, maintain access to services, and fund other necessary expenses that fall outside of the scope and payment structures of other available funding. Access funds may include but are not limited to startup funding to establish or expand access to services; costs associated with maintaining access to services; data and continuous quality improvement activities to identify, implement, and monitor critical performance measures; and workforce development to recruit, retain, and develop highly qualified staff to provide behavioral health services.

"Advocate" means advocate as defined in Iowa Code section 229.1.

"At-risk individuals" means individuals with access limits or functional needs (temporary or permanent) that indicate enhanced risk of development or exacerbation of a behavioral health condition or interfere with their ability to access care.

"At-risk populations" means groups of children, youth, young adults, adults, or older adults at higher risk of developing a behavioral health condition, including but not limited to individuals with disabilities, pregnant and parenting women, people with limited English proficiency, individuals with limited financial resources, people without access or means to access transportation, or individuals who lack a system of social support.

"Behavioral health" means mental health and addictive disorders and is inclusive of but not limited to mental illness, substance use, problem gambling, and tobacco and nicotine dependence.

"Behavioral health administrative services organization" or *"BH-ASO"* means the lead entities designated by the department to plan, develop, coordinate, and ensure behavioral health services throughout a district in accordance with the statewide behavioral health service system plan.

"Behavioral health care" means an integrated, recovery-oriented approach to care that acknowledges co-occurring conditions are the expectation, not the exception, and contemplates the full continuum of behavioral health prevention, education, early intervention, assessment, diagnosis, treatment, recovery, and crisis services and supports.

"Behavioral health condition" means the same as defined in Iowa Code section 225A.1.

"Behavioral health safety net service providers" or *"safety net providers"* means agencies that are primarily publicly funded; provide behavioral health services and supports with a focus on uninsured and underinsured individuals, at-risk populations and individuals, or special or targeted populations; coordinate care for individuals served; and meet minimum access standards. Behavioral health safety net service providers may receive access funds, training, tools, and technical assistance to provide a level of accessibility beyond that of other behavioral health providers.

"Behavioral health services" means services under any of the following domains on the behavioral health service continuum: prevention, early intervention, treatment, recovery, crisis services, and recovery supports.

"Behavioral health service system" means the same as defined in Iowa Code section 225A.1.

"Conflict of interest" means any activity that interferes or gives the appearance of interference with the exercise of professional discretion and impartial judgment.

"County of residence" means the same as defined in Iowa Code section 331.190.

"County of venue" means the county in which the Iowa Code chapter 229 commitment was filed pursuant to Iowa Code section 229.44.

"County where the individual is located" means the individual's county of residence as defined in Iowa Code section 331.190 or, if the individual has been ordered to receive treatment services under an Iowa

Code chapter 229 commitment and is placed in a residential or other treatment facility, the county in which the residential or other treatment facility is located.

"Crisis navigation" means activities to ensure that an individual in crisis is able to access appropriate crisis services in a timely manner and to transition an individual from crisis services to postcrisis care. This includes but is not limited to bed finding, coordination of transportation, system navigation, coordination of warm handoffs, and securing placements appropriate to meet individual needs.

"Crisis services" means services that focus on the immediate de-escalation and relief of the distress associated with a behavioral health crisis, reduce the risk that an individual in a crisis harms themselves or others, and provide aftercare and connection to ongoing follow-up to ensure postcrisis stabilization and reduce the reliance on high-acuity care or more restrictive environments.

"District" means a substate geographic area determined by the department to define the geographic boundaries of the behavioral health service system.

"District behavioral health service system plan" or *"district plan"* means a plan developed by the district BH-ASO and approved by the department to ensure access to behavioral health care and behavioral health services throughout a district.

"District contract" means a contract between the department and a BH-ASO. These contracts shall meet all applicable requirements of state and federal law.

"Early intervention" means intervention, service, or support provided to at-risk individuals to ameliorate or relieve early presenting symptoms prior to the development of a behavioral health condition or disorder.

"Education" means disseminating behavioral health knowledge or building resiliency skills through structured learning processes, including support of critical life and social skills such as decision-making, peer resistance and refusal, coping with stress, problem-solving, interpersonal communication, and improving judgment capabilities.

"Indicated prevention" means the same as defined in Iowa Code section 225A.1.

"Judicial district" means the same as described in Iowa Code section 602.6107.

"Minimum access standards" means standards to ensure equitable access to behavioral health services provided through the behavioral health service system, including but not limited to when and where services are made available, service and funding eligibility criteria, and behavioral health safety net service provider requirements.

"Prevention" means information dissemination; prevention education; alternative activities; wellness promotion; organizing, planning, and enhancing community-based processes; developing environmental approaches; and problem identification and referral designed to prevent the onset, reduce the impact, and mitigate the effects of a behavioral health condition.

"Primary substance use prevention" or *"universal prevention"* means activities designed to address the total population for the purpose of preventing exposures to hazards that cause disease or injury; altering unhealthy or unsafe behaviors that can lead to disease, disorder, or injury; and increasing resistance to disease, disorder, or injury should exposure occur.

"Provider contract" means a contract between a BH-ASO and a provider of behavioral health services. These contracts shall meet all applicable requirements of state and federal law.

"Recovery supports" means nonclinical assistance that facilitates recovery, wellness, and connection between individuals in recovery, service providers, and other supports known to enhance people's quality of life, including system navigation, peer recovery coaching, and peer support.

"Selective prevention" means the same as defined in Iowa Code section 225A.1.

"Special populations," for the purposes of the substance use prevention, treatment, and recovery services block grant (SUPTRS BG), means pregnant women, women with dependent children, individuals who use drugs through intravenous injection, and individuals who use substances and have tuberculosis.

"State behavioral health service system plan" or *"state behavioral health plan"* means the same as defined in Iowa Code section 225A.1.

"System navigation" means in-person, online, and telephonic support for problem-solving and navigation of the services and supports available. System navigators ensure individuals and families who

encounter barriers in accessing services and support are able to navigate health care, social services, and legal systems.

"Treatment" means clinical inpatient, outpatient, and residential care for individuals with a behavioral health condition or disorder diagnosed utilizing the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA) (published 2013, with all changes and updates approved by the APA through July 1, 2025, incorporated herein). The type, length, and intensity/frequency of interventions used by a behavioral health provider are based on the presenting symptoms of the individual.

"Underinsured" means an individual who has insurance coverage, but coverage limitations render reimbursement for behavioral health services ordered by a behavioral health service provider unavailable. Underinsured does not mean insurance coverage that has denied authorization of a service, denied payment of a covered service, or recouped a claim paid.

"Uninsured" means an individual who does not have insurance or whose insurance coverage is terminated for short periods of time.

This rule is intended to implement Iowa Code chapters 225A and 229.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

[Filed ARC 9274C (Notice ARC 9016C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTER 301
BEHAVIORAL HEALTH SERVICE SYSTEM ELIGIBILITY AND SERVICES

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

441—301.1(225A) Individual eligibility for behavioral health service system funding. To be eligible for behavioral health service system funding, an individual must meet the following financial and needs-based eligibility criteria.

301.1(1) *Financial eligibility.* Income requirements for adults and household income for children are as follows:

a. Income equal to or less than 200 percent of the federal poverty level.

b. Income will be verified using the best information available.

c. Financial eligibility will be reviewed on an annual basis and may be reviewed more often in response to increases or decreases in income.

d. An individual who is eligible for medical assistance must apply for and exhaust such funding for services and supports prior to utilization of behavioral health service system funding.

301.1(2) *Resource requirements.* Individuals seeking behavioral services must have resources that are equal to or less than $2,000 in countable value for a single-person household or $3,000 in countable value for a multiperson household.

a. The countable value of all countable resources, both liquid and nonliquid, will be included in the eligibility determination, except as exempted in this subrule.

b. A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.

c. The following resources will be exempt:

(1) A homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead will include all land that is contiguous to the home and the buildings located on the land.

(2) One automobile used for transportation.

(3) Tools of an actively pursued trade.

(4) General household furnishings and personal items.

(5) Burial account or trust limited in value as to that allowed in the medical assistance program.

(6) Cash surrender value of life insurance with a face value of less than $1,500 on any one person.

(7) Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

d. If an individual does not qualify for federally funded or state-funded services or other support but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources will additionally be considered exempt from consideration in eligibility determination:

(1) A retirement account that is in the accumulation stage.

(2) A medical savings account.

(3) An assistive technology account.

(4) A burial account or trust limited in value as to that allowed in the medical assistance program.

301.1(3) *Needs-based eligibility.* An individual must:

a. Be a resident of Iowa or, if a minor, the custodial parent or legal guardian is a resident of Iowa.

b. Currently have, or at any time during the preceding 12-month period have had, a behavioral health condition.

301.1(4) *Service-specific eligibility.* Notwithstanding the financial and needs-based eligibility requirements in subrule 301.1(1), 301.1(2), or 301.1(3), individuals may be subject to additional diagnostic, level of care, or admission requirements for services. Individuals receiving:

a. Twenty-three-hour observation and holding services must meet admission criteria set forth in 441—subrule 24.37(1).

b. Crisis stabilization community-based services must meet service eligibility requirements set forth in 441—subrule 24.38(1).

c. Crisis stabilization residential services must meet service eligibility requirements set forth in 441—subrule 24.39(1).

d. Covered substance use disorder treatment services must meet the applicable levels of the third edition of the American Society of Addiction Medicine (ASAM) Criteria as published by the ASAM and as amended to July 1, 2025.

e. Assertive community treatment (ACT) services must meet service eligibility requirements set forth in 441—subrule 78.45(1).

f. Subacute services must meet admission requirements set forth in 481—subrule 71.13(2).

g. Outpatient competency restoration must have a court order to receive the service pursuant to Iowa Code section 812.6.

h. Psychiatric medical institutions for children (PMIC) services must meet certification of need requirements set forth in rule 481—41.9(135H).

301.1(5) *Exceptions.* Receipt of the following behavioral health services is as defined and is not subject to individual eligibility criteria in subrule 301.1(1), 301.1(2), or 301.1(3):

a. Prevention.

b. Early intervention services.

c. Crisis services.

d. Outpatient competency restoration.

e. Jail-based behavioral health services.

f. System navigation.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—301.2(225A) The behavioral health care continuum.

301.2(1) *Behavioral health services.* Behavioral health services overseen by a BH-ASO will include ensuring access to the full continuum of behavioral health care, including:

a. Prevention services, including indicated prevention, primary substance use prevention and universal prevention, and selective prevention.

b. Early identification.

c. Early intervention services.

d. Crisis services, including immediate access to crisis assessment and evaluation; access centers; sobering centers; mobile crisis response; crisis-stabilization, community-based services; and crisis-stabilization, residential services.

e. Mental health outpatient treatment services, including screening, assessment, diagnosis, risk assessment, and crisis planning.

f. Mental health, high-intensity outpatient treatment services, including ACT, intensive outpatient programs (IOP), intensive psychiatric rehabilitation (IPR), partial hospitalization, and day treatment.

g. PMIC.

h. Mental health inpatient treatment.

i. Hospital alternatives, including subacute services, 23-hour observation and holding, and crisis respite services.

j. Substance use disorder outpatient treatment services, including assessment and evaluation services.

k. Substance use disorder intensive outpatient treatment services.

l. Substance use disorder partial hospitalization services.

m. Substance use disorder clinically managed residential treatment services.

n. Recovery supports.

o. Peer support and peer recovery coaching.

p. Peer wellness and recovery community centers.

q. Transitional living and recovery housing programs.

r. Jail-based behavioral health services, including provision of behavioral health treatment and medications in jails.

s. Commitment-related services, including prescreening, secure transportation, legal representation, and mental health advocates.

t. Outpatient competency restoration.

u. Outreach, education, and engagement services.

v. Additional services deemed necessary for a district or statewide as determined by the district behavioral health service system plan and approved by the department.

301.2(2) *Additional requirements.* Additional requirements related to behavioral health services include crisis system navigation that must be available 24 hours per day, 7 days per week, 365 days per year.

301.2(3) *Option for waiting lists.* The department will maintain a waiting list of individuals denied access to the program due to lack of available funds. Waiting list information will include the date on which the individual was placed on the waiting list. If additional funds become available, the department will contact individuals on the list.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—301.3(225A) Provider qualifications.

301.3(1) *Behavioral health safety net service providers.* Behavioral health safety net service providers, which are defined in rule 441—300.1(225A), are required to:

a. Adhere to minimum access standards as set forth in 441—subrule 302.2(1).

b. Accept behavioral health service system funds as payment in full for individuals served through behavioral health service system funding. The safety net provider may not bill individuals for missed appointments, or for copayments or other cost-sharing arrangements, except as described in individual eligibility standards in rule 441—301.1(225A).

c. Work with BH-ASOs to coordinate care for the individuals the safety net provider serves, including making referrals to secure services and supports appropriate for the individual, coordinating warm handoffs to ensure continuity of care, coordinating transportation, and performing post-discharge follow-up.

d. Notify the BH-ASO within seven days when a safety net provider is at or above 90 percent capacity to admit individuals in need of behavioral health services.

301.3(2) *Behavioral health service system provider eligibility.* The following persons or organizations are eligible to participate as behavioral health service system providers to the extent allowed under the scope of their licensure, certification, or accreditation:

a. Hospitals providing inpatient psychiatric treatment or emergency department services licensed pursuant to Iowa Code chapter 135B.

b. Providers of outpatient mental health services licensed to practice in the state of Iowa or accredited under 441—Chapter 24.

c. Providers of crisis services accredited under 441—Chapter 24.

d. Community mental health centers (CMHCs) accredited under 441—Chapter 24.

e. Certified community behavioral health clinics (CCBHCs) certified by the department.

f. Federally qualified health centers (FQHCs) certified by the Centers for Medicare and Medicaid Services (CMS).

g. Providers of substance use disorder treatment programs and problem gambling treatment programs licensed pursuant to 641—Chapter 155.

h. Local tobacco control programs designated by the department.

i. Recovery community centers (RCCs) designated by the department.

j. Providers of recovery support services (RSSs) designated by the department.

k. Subacute mental health facilities licensed pursuant to 481—Chapter 71.

l. PMICs licensed pursuant to 481—Chapter 41.

m. Providers of prevention services designated by the department.

n. Providers of early intervention services designated by the department.

o. Recovery and peer support providers trained or certified through approved programs designated by the department.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—301.4(225A) Appeal rights.

301.4(1) *Definitions.* For the purposes of this rule, the following definitions apply.

"Agency action" includes the whole or part of an agency rule or other statement of law or policy, order, decision, license, proceeding, investigation, sanction, relief, or the equivalent or a denial thereof, or a failure to act, or any other exercise of agency discretion or failure to do so, or the performance of any agency duty or the failure to do so.

"Appellant" means any person bringing an appeal under this chapter, including any person's authorized representative as defined in subrule 301.4(14).

"Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

"Reviewer" means the individual assigned by the department to review an appeal record and issue a written decision on behalf of the department. The department's reviewer will be screened from the underlying case and will not have prior knowledge of the facts that precipitated the appeal.

301.4(2) *Appeal.* A person that disagrees with the department's agency action related to an eligibility determination or denial of behavioral health services may request an appeal within 120 calendar days of the date of the determination or denial.

a. The following actions may be appealed:

(1) The determination that eligibility criteria have not been met.

(2) The denial or limited authorization of a requested service, including the type or level of service.

(3) The decision to reduce, suspend, or terminate previously authorized services.

(4) The denial, in whole or in part, of payment for a service that was provided.

(5) The failure of the department to act within the required time frames.

b. Appeal requests submitted by regular mail are considered filed on the date postmarked on the envelope sent to the department or, when a postmarked envelope is not available, on the date the appeal is stamped received by the department. Appeal requests sent electronically are considered filed on the date on which the electronic submission was completed.

c. In computing any time period specified in this rule, the period:

(1) Excludes the day of the event that triggers the period;

(2) Includes every day of the time period (including Saturdays, Sundays, and holidays on which the department is closed); and

(3) Includes the last day of the period, but if the last day is a Saturday, Sunday, or legal holiday, the period continues until the end of the next day that is not a Saturday, Sunday, or legal holiday.

301.4(3) *Request.* The person may request an appeal using a form prescribed by the department and in a manner prescribed by the department.

301.4(4) *Acknowledgment of appeal.* The department will send an acknowledgment of receipt of the appeal to the parties-in-interest to the appeal.

301.4(5) *Acceptance or denial of appeal.* The department will determine with reasonable promptness whether the person is entitled to an appeal. If a request for an appeal is denied, the department will provide written notice of and the reasons for the denial. On or before the thirtieth calendar day following the denial of appeal, the party requesting the appeal may provide additional information related to the appeal and request reconsideration of the denial of the appeal.

301.4(6) *Documentation.* If an appeal request is granted, the appellant may submit a written statement, supported by relevant documentation, to establish all pertinent facts and circumstances. Documents shall be submitted to the department within 14 calendar days of the date the appeal is acknowledged. The department's reviewer may request additional documents or information from the appellant as needed to assist the department's evaluation of the appeal.

301.4(7) *Ex parte communication.* The department's reviewer, the director, and all parties to the appeal are bound by the rules against ex parte communication set forth in Iowa Code section 17A.17 and rule 7—2506.23(17A).

301.4(8) *Withdrawal.* An appellant may withdraw a request for appeal at any time. Requests to withdraw an appeal will be granted.

301.4(9) *Department review.* The department's reviewer will review the appeal record and issue a written proposed decision to all parties within 30 calendar days. The written proposed decision will include the reviewer's findings of fact and rationale for the decision.

301.4(10) *Director's review.*

a. Time. Parties may appeal the proposed decision to the director. A request for director's review shall be in writing and postmarked or received within 14 calendar days of the date on which the proposed decision was issued. A request for director's review may be accompanied by a brief written summary of the arguments in favor of granting a director's review.

b. Granting or denial of review. The department has full discretion to grant or deny a request for director's review. In addition, the director may initiate review of a proposed decision on the director's own motion at any time on or before the thirtieth calendar day following the issuance of the proposed decision. When the department grants a request for director's review, the parties will be notified of the decision, and a copy of the request will be included with the notification.

c. Limited record. A director's review will be limited to the issues and information contained in the record reviewed by the reviewer who issued the proposed decision.

d. Oral arguments. Upon specific request, the director may, at the director's discretion, permit parties to present oral arguments with the parties' requests for director's review.

e. Decision issued. The director will issue a final decision within the timelines prescribed by federal or state law. For all appeals for which there is no federal or state timeliness standard, the director will issue a final decision on or before the ninetieth day from the date the director grants review.

301.4(11) *Final decisions.*

a. No appeal or denial of director review. If there is no timely appeal from or review of the proposed decision, the proposed decision will be considered the final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

b. Director decision issued. Any decision issued by the director after granting a director's review will be considered the final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

c. Written notice of final decision. The parties-in-interest will be provided written notice of the department's final decision. The department will also notify the appellant of the right to seek judicial review, where applicable.

301.4(12) *Interpreters.* The department will provide translation and interpretation services to parties-in-interest, if requested. When a party-in-interest is illiterate or semiliterate, the reviewer will advise the party-in-interest of the party-in-interest's rights.

301.4(13) *Persons living with disabilities.* Persons living with disabilities will be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act (as amended, effective December 31, 2023) and Section 504 of the Rehabilitation Act (as amended, effective October 1, 2016).

301.4(14) *Authorized representatives.*

a. Regulations. The provisions of this subrule only apply to the extent the standards expressed in this rule are not in conflict with other state or federal law.

b. Designation of authority. Legally recognized delegations of authority, such as guardianships, applicable designations of power of attorney, or similar designations, will be sufficient for a delegate to serve as authorized representative under this rule. A person that is not designated as a legally recognized delegation of authority but who otherwise seeks to act as an authorized representative for an individual in an appeal under this rule shall provide a written, signed designation of authority to the department with the request for appeal. The designation must provide the scope of the representation, applicable waivers for the release of confidential information, and any temporal or other limitations on the scope of representation. An authorized representative of a party-in-interest only represents the party-in-interest and has no independent right to appeal by virtue of the authorized representative's representation.

c. Appearance by attorney. Legal counsel appearing on behalf of any person in a proceeding under this rule shall enter an appropriate written appearance.

301.4(15) *Not contested cases.* Appeals brought under this chapter are not contested cases, appellants will not be granted a contested case hearing, and the provisions in 441—Chapter 2506 do not apply.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26; Editorial change: IAC Supplement 9/2/26]

These rules are intended to implement Iowa Code chapter 225A.

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

[Editorial change: IAC Supplement 9/2/26]

CHAPTER 302
BEHAVIORAL HEALTH ADMINISTRATIVE SERVICE ORGANIZATIONS

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

441—302.1(225A) Implementation and maintenance of programs and services.

302.1(1) *Authority to designate BH-ASOs.* The department will designate one BH-ASO for each district as set forth in Iowa Code chapter 225A. The department will enter into a contract with a designated BH-ASO to coordinate and oversee behavioral health services in one or more behavioral health district. If the department terminates its contract with a BH-ASO for any reason, the entity is no longer designated by the department as a BH-ASO.

302.1(2) *Community needs assessment.* A BH-ASO will complete an assessment of community needs to identify behavioral health service system strengths, gaps, and emerging issues within its district.

302.1(3) *District behavioral health service system plan.* A BH-ASO will collaborate with the district behavioral health advisory council and other stakeholders to develop a district behavioral health service system plan to describe all behavioral health services and supports and other activities in support of the behavioral health system to be delivered by the BH-ASO.

302.1(4) *BH-ASO operations.* A BH-ASO will implement its approved district plan and maintain operations necessary to meet its obligations under state and federal laws and regulations and as established in the district contract.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—302.2(225A) Service availability and accessibility.

302.2(1) *Minimum access standards.* A BH-ASO will ensure available, accessible, and adequate numbers of providers, locations, and personnel for the provision of behavioral health services. At a minimum, access to services provided by behavioral health safety net service providers will meet the following standards:

a. Crisis assessment and evaluation. An individual will have immediate access to a crisis screening and will have a crisis assessment by an appropriately licensed or credentialed mental health or substance use disorder treatment professional within 24 hours of referral.

b. Access centers. An individual will have access to services within 60 minutes or 60 miles of an individual's residence.

c. Mobile crisis response. An individual will have an in-person, community-based response within 60 minutes.

d. Crisis-stabilization, community-based services. An individual will have access to services within the time frames set forth in 441—Chapter 24.

e. Crisis-stabilization, residential services. An individual will have access to services within the time frames set forth in 441—Chapter 24.

f. Mental health outpatient.

(1) The service will be located within 60 minutes or 60 miles of an individual's residence.

(2) During an emergency, outpatient services shall be initiated to an individual within 15 minutes of telephone contact. When the assessed need is urgent, outpatient services shall be provided to an individual within one hour of presentation or 24 hours of telephone contact. When the assessed need is for routine care, outpatient services shall be provided to an individual within four weeks of the individual's request for appointment.

g. Assertive community treatment. The service will be available to all individuals within a district.

h. Mental health intensive psychiatric rehabilitation. An individual will have access to services within the time frames set forth in 441—Chapter 24.

i. Mental health inpatient. The service will be located within 60 minutes or 60 miles of an individual's residence in urban areas and within 90 minutes or 90 miles of an individual's residence in rural areas.

j. Substance use disorder outpatient treatment. An individual will have access to services within 60 minutes or 60 miles of the individual's residence.

k. Substance use disorder intensive outpatient services. An individual will have access to services within 60 minutes or 60 miles of an individual's residence.

l. Substance use disorder residential treatment services. An individual will have access to services within 60 minutes or 60 miles of an individual's residence.

m. Outpatient competency restoration. The service will be available to all individuals within a district.

n. Twenty-three-hour observation and holding. An individual will have access to services within the time frames set forth in 441—Chapter 24.

o. Crisis respite. An individual will have access to services within the time frames set forth in 441—Chapter 24.

302.2(2) *Priority populations for substance use disorder treatment.* In addition to the standards in subrule 302.2(1), behavioral health safety net service providers of substance use disorder treatment will meet the following standards:

a. In accordance with 45 CFR Part 96, Subpart L, as amended to July 1, 2025, priority admission to substance use disorder treatment services must be offered to the following populations in this order:

(1) Individuals who are pregnant and who use injection drugs.

(2) Individuals who are pregnant.

(3) Individuals who use injection drugs.

(4) All others.

b. Individuals who are pregnant must be admitted to the recommended American Society of Addiction Medicine (ASAM) level of care within 48 hours of receiving the recommendation for treatment from a licensed substance use disorder treatment provider. If admission is not possible within 48 hours, the individual must be offered interim services as defined in 45 CFR 96.121 as amended to July 1, 2025, and must be referred to the statewide waitlist maintained by the department.

c. Individuals who report the use of injection drugs and are not pregnant must be admitted to the recommended ASAM level of care within 14 days of receiving the recommendation for treatment from a licensed substance use disorder treatment provider. If admission is not possible within 14 days, interim services must be offered within 48 hours and the admission deadline is then extended to 120 days.

302.2(3) *Free choice of providers.* A BH-ASO will ensure that individuals may receive services from any qualified network provider of the individual's choosing that is available to provide the services to them.
[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—302.3(225A) Provider oversight and monitoring.

302.3(1) *Provider contracts.* To receive payment for services through a BH-ASO, providers of behavioral health services must have a provider contract with the BH-ASO. Providers that are eligible to enroll with the Iowa Medicaid program must also be enrolled as an Iowa Medicaid provider.

302.3(2) *Claim submission.* Providers of behavioral health services will submit claims for services on at least a monthly basis.

a. Claims for services rendered for persons eligible for Medicaid will be submitted to the managed care organization with which the person is enrolled in accordance with the managed care organization's claim submission policies.

b. Claims for services rendered for persons not eligible for Medicaid will be submitted to the Iowa Medicaid program according to the process set by the department for BH-ASO claims and will meet the following requirements:

(1) Claims will be submitted electronically on the proper claim forms following the requirements set forth in rule 441—80.2(249A).

(2) Claims will follow the time limits for claim submission set forth in rule 441—80.4(249A).

302.3(3) *Provider monitoring.* A BH-ASO will conduct monitoring activities to oversee providers of behavioral health services within the district and monitor the Iowa Medicaid provider sanction list and take the following actions:

a. For any behavioral health provider suspended by Medicaid, suspend participation in the BH-ASO provider network within 30 days.

b. For any behavioral health provider terminated by Medicaid, terminate participation in the BH-ASO provider network within 30 days.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code chapter 225A.

[Filed ARC 9274C (Notice ARC 9016C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTER 303
Reserved

CHAPTER 304
DISTRICT BEHAVIORAL HEALTH ADVISORY COUNCILS

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

441—304.1(225A) Definitions. For the purpose of this chapter, the following definitions apply:

"Chairperson" means the chairperson of the district behavioral health advisory council who has been elected by a majority of advisory council members.

"District behavioral health advisory council" or *"advisory council"* means the same as defined in Iowa Code section 225A.1.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—304.2(225A) Appointment.

304.2(1) The members of the advisory council will be appointed by the BH-ASO in accordance with the parameters of Iowa Code section 225A.5.

304.2(2) The appointments will be for three-year staggered terms that expire on June 30.

304.2(3) Vacancies will be filled in accordance with requirements established in the district contract. Members appointed to fill a vacancy will serve for the balance of the unexpired term.

304.2(4) Absences.

a. Three unexcused absences in a 12-month period constitutes grounds for the BH-ASO to request nomination of an alternate representative to fill the position.

b. Absences may be excused by notification provided to the chairperson prior to the meeting.

c. The chairperson of the advisory council is charged with providing notification of absences to the BH-ASO.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—304.3(225A) Officers.

304.3(1) Officers of the advisory council will consist of a chairperson and a vice chairperson, who will be elected at the first meeting of each fiscal year.

a. An officer may serve no more than three consecutive terms as chairperson or vice chairperson.

b. A vacancy in the office of chairperson will be filled by elevation of the vice chairperson.

c. A vacancy in the office of vice chairperson will be filled by election at the next meeting after the vacancy occurs.

d. A vacancy must be filled by an individual meeting the same qualifications as the departing advisory council member in accordance with Iowa Code section 225A.5.

304.3(2) Duties of officers.

a. The chairperson will:

(1) Preside at all meetings of the advisory council;

(2) Appoint subcommittees as deemed necessary; and

(3) Designate the chairperson of each subcommittee.

b. The vice chairperson will:

(1) Perform the duties of the chairperson if the chairperson is absent or unable to act. When so acting, the vice chairperson will have all the powers of and be subject to all restrictions upon the chairperson.

(2) Perform other duties as may be assigned by the chairperson.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—304.4(225A) Meetings.

304.4(1) The advisory council will establish a meeting schedule on an annual basis to conduct its business. There will be a minimum of four meetings per year.

304.4(2) A majority of appointed members constitutes a quorum.

304.4(3) When a quorum is present, a position is carried by affirmative vote of the majority of those present. No official business that requires a vote of the membership will be conducted without a quorum present.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—304.5(225A) Subcommittees. The advisory council may designate one or more subcommittees to perform such duties as may be deemed necessary.
[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—304.6(225A) Advisory council composition. The advisory council's composition will be developed and maintained pursuant to Iowa Code chapter 225A.
[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 225A.5.

[Filed ARC 9274C (Notice ARC 9016C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTER 305
MENTAL HEALTH ADVOCATES

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

441—305.1(229) Advocate appointment and qualifications. The board of supervisors of each county will appoint a person to act as an advocate representing the interests of individuals involuntarily hospitalized by the court under Iowa Code chapter 229. The advocate is hired by the board of supervisors and employed by the county.

305.1(1) *Appointment.* A person may be appointed and employed or contracted with as the advocate by one county or by multiple counties. Advocates may be appointed for counties in more than one judicial district or more than one district.

305.1(2) *Qualifications.* The advocate will meet the following qualifications:

a. Possess a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field, including but not limited to psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy, and at least one year of experience in the delivery of services to persons with mental illness; or

b. Hold an Iowa license to practice as a registered nurse and have at least three years of experience in delivery of services to persons with mental illness.

c. A person employed as an advocate on or before July 1, 2015, who does not meet the requirements of paragraph 305.1(2)*"a"* or *"b"* will be considered to meet those requirements so long as the person is continuously appointed as an advocate in the employing county.

d. A person employed as an advocate must pass criminal background, sex offender registry, and child and dependent adult abuse registry checks prior to the advocate's hire.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—305.2(229) Advocate assignment. The committing court will assign the advocate from the county where the individual is located.

305.2(1) If the advocate assigned cannot serve the individual in an effective and efficient manner, the advocate may request another advocate to perform advocate duties on the individual's behalf. In the event that another advocate can better represent the individual on a longer-term basis, the advocate will request that the court transfer the individual to another advocate.

305.2(2) When a conflict of interest is identified between an advocate and an individual, the court and the advocate's county of employment will be notified and an alternative advocate will be assigned. The advocate's direct supervisor is responsible to monitor and ensure that the advocate does not have a conflict of interest. In instances when dual or multiple relationships are unavoidable, advocates should take steps to protect individuals and are responsible for setting clear, appropriate, and culturally sensitive boundaries. Advocates who anticipate a conflict of interest among the individuals receiving services should clarify the advocate's role with the parties involved and take appropriate action to minimize any conflict of interest.

305.2(3) When the advocate assigned is not the advocate from the individual's county of residence, the advocate's county of employment may seek reimbursement from the BH-ASO for the district in which the individual's county of residence is located as outlined in Iowa Code section 229.19(1)*"b."*

305.2(4) An advocate will only be assigned to a child 17 years of age or under when the child is not represented by an attorney due to an existing child in need of assistance (CINA) or other juvenile court action pursuant to the Iowa Code.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—305.3(229) Advocate responsibilities. The minimum duties of the advocate are outlined in Iowa Code section 229.19. The role of the advocate is to ensure that the rights of the individual are upheld.

305.3(1) The advocate will be readily accessible to communication from the individual and will initiate contact within five days of the individual's commitment. The advocate will inform the individual regarding the role of the advocate.

305.3(2) The advocate will meet the individual in person within 15 days of the individual's commitment. The advocate will present the county grievance procedure process, in writing, to the individual. The presentation will include the county grievance procedure, county contact information, and ombudsman contact information. The advocate will inform the individual about the mental health crisis services that are available.

305.3(3) The advocate will review each report submitted to the court and communicate with the individual's medical and treatment team. Advocates will abide by all federal, state, and local confidentiality laws.

305.3(4) The advocate will file in a form prescribed by the court as the advocate feels necessary or as required for each individual assigned to the advocate.

305.3(5) The advocate will maintain an organized, confidential, and secure file for each individual served. The file will contain but not be limited to:

a. Copies of quarterly reports submitted to the court.

b. Copies of correspondence sent to and received from the individual, family members, providers, and others.

c. Releases of information.

d. Case notes describing the date, time, and type of contact with the individuals or others and a brief narrative summary of the content or outcome of the contact.

e. Documents filed with the court electronically will be considered as part of the individual's file.

305.3(6) The advocate will register as provided in Iowa R. Elec. P. 16.305(1) to participate in the court's electronic document management system and will submit all documents to be filed with the court electronically. The documents will be stored as electronic records that are retrievable and readable through the electronic document management system.

305.3(7) The advocate, as an employee of the county, will comply with all county policies and procedures, including but not limited to hiring, supervision, grievance procedures, and training.

305.3(8) All advocate records are the property of the county, which is responsible for the provision of confidential storage, transfer, and destruction of client files, including those maintained on electronic and digital devices, with access limited according to the county's policy on confidentiality as described in subrule 305.4(6).

305.3(9) The advocate may attend the hospitalization hearing of an individual represented by an attorney; however, payment for the advocate's attendance is at the discretion of the county of employment.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—305.4(229) County responsibilities. As the employer of the advocate, the county will provide qualified staff to support and facilitate the provision of quality advocate services. The county will:

305.4(1) Assign a single supervisor, a single contract manager, or the county board of supervisors as the supervising entity to carry out responsibilities in this chapter.

305.4(2) Have a job description in the personnel file of the advocate that clearly defines the advocate's responsibilities and qualifications as defined in Iowa Code section 229.19 and this chapter.

305.4(3) Have a process to verify, prior to the advocate's hire, qualification of the advocate, including degrees and certifications obtained from a primary source.

305.4(4) Provide or arrange for training and education relevant to the position, including but not limited to overview of mental health diagnosis and treatment, the behavioral health service system, confidentiality, individual rights, professional conduct, the role of advocacy and service coordination within an interdisciplinary team, the Iowa Code and administrative rules, and court procedures.

305.4(5) Provide or arrange for approved training on child and dependent adult abuse reporter requirements.

305.4(6) Provide, to any employee with access to individuals' files, training on state and federal laws regarding nondisclosure and confidentiality of client-protected health information during and after employment and maintain in the personnel files a signed document indicating the employee's awareness of the county's policy on confidentiality.

305.4(7) Complete criminal background, sex offender registry, and child and dependent adult abuse registry checks before employment of the advocate. Any person who does not pass these checks is prohibited from being hired, or continuing to serve, as an advocate.

305.4(8) Provide advocate staff to cover the county's caseload at all times, according to but not limited to each county's unique number of individuals assigned to the advocate, travel required, types of settings where the individuals reside, services available, and extended staff absences.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—305.5(229) Data collection requirements.

305.5(1) *Annual submission.* By December 1 of each year, each county will submit to the department data regarding each individual who received advocate services during the previous state fiscal year.

305.5(2) *Required data.* The data to be submitted are as follows:

a. Basic information about the individual, including a unique identifier and county of residence.

b. Demographic information, including the individual's date of birth, sex, ethnicity, education, and diagnosis made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA) (published 2013, with all changes and updates approved by the APA through July 1, 2025, incorporated herein).

c. Commitment information, including the date of the individual's initial commitment, type of commitment order, whether a juvenile or adult case, date of commitment and name of treatment facility to which the individual is committed, any subsequent changes in treatment facility, and date commitment is terminated.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

441—305.6(229) Quality assurance system. The county will implement a quality assurance system that:

305.6(1) Annually measures and assesses advocates' activities and services.

305.6(2) Gathers feedback from stakeholders, including individuals using advocate services, family members, court staff, service provider staff, and BH-ASO staff regarding advocate services.

305.6(3) Implements an internal review of individual records.

305.6(4) Identifies areas in need of improvement.

305.6(5) Develops a plan to address the areas in need of improvement.

305.6(6) Implements the plan and documents the results.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code chapter 229.

[Filed ARC 9274C (Notice ARC 9016C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTER 306
OPIOID SETTLEMENT FUND DISBURSEMENT

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/1/31

441—306.1(12) Definition.

"Fund" means the opioid settlement fund created in Iowa Code section 12.51.

[**ARC 0111D**, IAB 3/4/26, effective 5/1/26]

441—306.2(12) Methodology. To facilitate the fund disbursement required by Iowa Code section 12.51, the department may solicit requests for proposals pursuant to rules of the department of administrative services each fiscal year, starting with the fiscal year beginning July 1, 2025. The department may pursue additional funding mechanisms as fund availability and opportunities allow.

[**ARC 0111D**, IAB 3/4/26, effective 5/1/26]

441—306.3(12) Outcome measurement. Subsequent to the awarding of disbursements, the department will formulate indicators to be used to help identify if the outcomes intended for each disbursement are being met. Intended outcomes can include but are not to be limited to prevention of opioid-related deaths, reduction of opioid misuse, and increased access to appropriate medication and services.

[**ARC 0111D**, IAB 3/4/26, effective 5/1/26]

441—306.4(12) Annual report. Starting with the fiscal year beginning on July 1, 2025, on or before November 1, the department will annually submit to the general assembly and to the governor a report that includes the elements required by Iowa Code section 12.51(2)*"b"*(3)(d).

[**ARC 0111D**, IAB 3/4/26, effective 5/1/26]

These rules are intended to implement Iowa Code section 12.51.

[Filed ARC 0111D (Notice ARC 9844C, IAB 12/24/25), IAB 3/4/26, effective 5/1/26]

CHAPTERS 307 to 309
Reserved

CHAPTER 310
DATA COLLECTION

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

441—310.1(225A) Authority. The director is the principal officer of the state to administer BH-ASO data reporting. On behalf of the department, each BH-ASO will collect and maintain data on all clients served.

310.1(1) *Submission of data.* Each BH-ASO will submit to the department the data regarding each individual the BH-ASO serves.

a. BH-ASOs will submit data according to the frequency, file layouts, format, and naming conventions prescribed by the department.

b. When a BH-ASO is notified by the department that the data is incomplete or is not compliant with the prescribed file layouts, format, or naming conventions, the BH-ASO must correct the issue within 30 days of the notification.

c. The state supplementary assistance program, mental health institutes, state resource center, Medicaid program, Medicaid managed care organizations, and targeted case management program will provide to the department team responsible for BH-ASO evaluation and oversight the equivalent data in a compatible format on the same schedule as the required submission from the BH-ASOs as requested.

310.1(2) *Data required.* The data to be submitted are as follows:

a. Individual client-level information, including a unique identifier, name, address, demographic information, service delivery information, referral information, and any other information as prescribed by the department.

b. The state ID number when applicable.

c. Demographic information, including but not limited to date of birth, sex, ethnicity, marital status, education, residential living arrangement, current employment status, monthly income, income sources, type of insurance, insurance carrier, veterans' status, guardianship status, legal status in the system, source of referral, and diagnosis code in the International Classification of Diseases (ICD) as amended to July 1, 2025.

d. Service information, including but not limited to the decision on services, date of decision, termination date and reason for termination, residence, approved service, service beginning dates, service ending dates, reason for terminating each service, approved units of services, unit rate for service, expenditure data, and provider data.

This rule is intended to implement Iowa Code sections 225A.3 and 225A.6.

[**ARC 9274C**, IAB 5/14/25, effective 7/1/25]

[Filed ARC 9274C (Notice ARC 9016C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

CHAPTERS 311 to 2503
Reserved

CHAPTER 2504
RULE WAIVERS

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

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.
[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2504.3(17A) Evaluation.

2504.3(2) The agency will evaluate the petition in accordance with Iowa Code section 17A.9A. The agency may request additional information from the petitioner or any person as part of its evaluation of the petition.

7—paragraphs 2504.3(2)*"a"* and *"b"* are not adopted.
[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

[Filed Emergency ARC 0300D, IAB 5/27/26, effective 7/1/26]

CHAPTER 2505
FAIR INFORMATION PRACTICES

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

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.
[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2505.1(17A,22) Definitions. As used in this chapter:

"Client" means a person who has applied for or received services or assistance from the agency.

"Disclosure" means the same as defined in 45 CFR §160.103 as amended to June 25, 2024.

"Health care operations," for covered entities in the agency, means the same as defined in 45 CFR §164.501 as amended to March 26, 2013.

"Payment," with respect to protected health information, means the same as defined in 45 CFR §164.501 as amended to March 26, 2013. For the agency's purposes, "payment" applies to subjects for whom health care coverage is provided under the Medicaid program or the hawki program.

"Protected health information" or *"PHI"* means the same as defined in 45 CFR §160.103 as amended to July 1, 2026.

"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 agency.

"Subject" means the person who is the subject of the record, whether living or deceased.

"Treatment" means the same as defined in 45 CFR §164.501 as amended to March 26, 2013.

"Use," with respect to PHI, means the same as defined in 45 CFR §160.103 as amended to July 1, 2026.
[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2505.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination.

2505.5(4) The agency shall also allow individuals to request restrictions on the use or disclosure of PHI and alternative means of confidential communication, consistent with 45 CFR §164.522 as amended to July 1, 2026. The agency will maintain written procedures for processing such requests and document any granted restrictions.
[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2505.7(17A,22) Consent to disclosure by the subject of a confidential record.

2505.7(1) The agency shall include provisions for disclosures of confidential information consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any applicable state or federal law as amended to July 1, 2026, including:

a. Emergency exceptions;
b. Disclosures requiring opportunity to agree or object;
c. Disclosures when an individual is not present;
d. Disaster relief disclosures; and
e. Routine disclosures for:
(1) Internal operations;
(2) Contractors and agents working on behalf of the agency;
(3) Judicial or administrative proceedings;
(4) Medicaid billing;
(5) Child support recovery; and
(6) Research purposes.

2505.7(2) Additionally, the agency shall maintain written policies for general uses and disclosures of PHI for treatment, payment, and health care operations.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2505.9(22,252G) Personally identifiable information. The nature and extent of personally identifiable information collected by the agency varies by the type of record. This rule describes personally identifiable information collected, maintained, and retrieved by the agency by personal identifiers in record systems and the legal authority for the collection of that information. This rule also identifies the legal authority for keeping some or all of the collected personally identifiable information confidential.

2505.9(1) Agency administrative records.

a. Personnel records. These records contain information about employees, families and dependents, and applicants for positions with the agency. Some of this information is confidential under Iowa Code section 22.7(11) and 22.7(18).

b. Fiscal records. These records contain itemized vouchers collected from individuals pursuant to Iowa Code section 8A.514. Some of this information is confidential under Iowa Code section 22.7(11) and 22.7(18).

c. Litigation files. These files or records contain information regarding litigation or anticipated litigation, which includes judicial and administrative proceedings. The records include briefs, depositions, docket sheets, documents, correspondence, attorney's notes, memoranda, research materials, witness information, investigation materials, information compiled under the direction of the attorney, and case management records. The files contain materials that are confidential as attorney work product and attorney-client communications. Some materials are confidential under other applicable provisions of law or because of a court order. Persons wishing copies of pleadings and other documents filed in litigation should obtain them from the clerk of the appropriate court that maintains the official copy. These records are confidential as outlined in Iowa Code sections 217.30, 22.7(4) and 622.10.

2505.9(2) Program records.

a. Adoption investigator certification. These records are collected pursuant to Iowa Code chapter 600.

b. Adoption program records. These records are collected pursuant to Iowa Code sections 600.8 and 600.16. These records are confidential as outlined in Iowa Code sections 600.16 and 600.24.

c. Appeals. These records are collected pursuant to Iowa Code section 217.1A. Some of these records are confidential as outlined in Iowa Code section 217.1A. Each appeal to the department will be governed by the specific state and federal laws that control it.

d. AIDS drug reimbursement program. These records are collected for purposes of implementing a federal grant program authorized by HR 1827 as amended to June 27, 1987. Certain patient records are confidential as outlined in Iowa Code section 141A.9.

e. Brain injury service program recipients. These records are collected pursuant to Iowa Code section 135.22B. These records are confidential as outlined in Iowa Code section 135.22(2).

f. Congenital and inherited disorders. These records are collected pursuant to Iowa Code chapter 136A. These records are confidential as outlined in Iowa Code section 136A.7.

g. Central registry for brain or spinal cord injuries. These records are collected pursuant to Iowa Code section 135.22. Except for statistical reports, these records are maintained as confidential pursuant to Iowa Code section 135.22.

h. Child abuse program. These records are collected pursuant to Iowa Code section 235A.14. These records are confidential as outlined in Iowa Code sections 235A.13, 235A.15, 235A.16, and 235A.17.

i. Child care assistance client records. These records are collected pursuant to Iowa Code chapter 237A. These records are confidential as outlined in Iowa Code section 237A.13.

j. Child care facility licensing. These records are collected pursuant to Iowa Code chapter 237A. Some of these records are confidential as outlined in Iowa Code section 237A.7.

k. Childhood lead poisoning prevention program. These records are collected pursuant to Iowa Code sections 135.100 through 135.105. Certain records are confidential as outlined in Iowa Code chapter 139A.

l. Child support recovery program. These records are collected pursuant to Iowa Code chapters 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 252I, 252J, and 252K and sections 144.13, 144.26, 232.147, 234.39, 595.4, 598.22B and 600.16A. These records are confidential as outlined in Iowa Code

sections 252B.9 and 252G.5; 42 U.S.C. §654(26) as amended to July 1, 2026; 42 U.S.C. §654a(d) as amended to July 1, 2026; and 45 CFR §303.21 and §307.13 both as amended to July 1, 2026.

m. Chronic disease prevention and management programs. These records are collected pursuant to Iowa Code section 135.11(1). Certain medical information in these records is confidential as outlined in Iowa Code section 22.7(2).

n. Collection service center payment. These records are collected pursuant to Iowa Code sections 252B.9, 252B.13A and 252B.16. These records are confidential as outlined in Iowa Code section 252B.9(2) and 42 U.S.C. §654a(d) and 45 CFR §307.13 both as amended to July 1, 2026.

o. Criminal and juvenile justice information. These records are collected pursuant to Iowa Code sections 216A.136 and 216A.138 and through interagency agreements.

p. Dental health program. These records are collected pursuant to Iowa Code section 135.11(14). Certain medical information in these records is confidential as outlined in Iowa Code section 22.7(2).

q. Dependent adult abuse program. These records are collected pursuant to Iowa Code section 235B.1. These records are confidential as outlined in Iowa Code section 235B.1.

r. Domestic abuse death review. These records are collected pursuant to Iowa Code section 135.110. These records are confidential as outlined in Iowa Code section 135.111.

s. Emergency medical services. These records are collected pursuant to Iowa Code chapter 147A.

t. Environmental health program. These records are collected pursuant to Iowa Code section 135.11(1); PL 96-510, Section 104(d)(1); 40 CFR 763 effective June 28, 1983; and 40 CFR 761 effective May 31, 1979, and both as amended to July 1, 2026, dealing with asbestos, PCB and other environmental health factors. Certain medical information in the work-related disease program file may be confidential as outlined in Iowa Code section 22.7(2). Certain asbestos and PCB inspection records are collected under contract with the federal Environmental Protection Agency, and requests for such records will be referred to that agency.

u. Family investment program client records. These records are collected pursuant to Iowa Code section 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §602(a)(1) and §1306a as amended to July 1, 2026.

v. Food assistance client files. These records are collected pursuant to Iowa Code section 234.6. These records are confidential as outlined in Iowa Code section 217.30; 7 U.S.C. §2020(e)(8) as amended to July 1, 2026; and 7 CFR §272.1(c) and (d) as amended to June 23, 2000.

w. Foster care client/service files. These records are collected pursuant to Iowa Code sections 237.3 through 237.5. These records are confidential as outlined in Iowa Code section 237.9.

x. Foster care facility licensing. These records are collected pursuant to Iowa Code chapter 237. Some of these records are confidential as outlined in Iowa Code section 237.9.

y. Foster care review board files. These records are collected pursuant to Iowa Code section 237.17. Some of these records are confidential as outlined in Iowa Code section 237.21.

z. Hawki client files. These records are collected pursuant to Iowa Code section 514I.4. These records are confidential as outlined in Iowa Code section 514I.4 and 42 CFR §457.1110 as amended to January 1, 2001.

aa. Human rights advocacy files. These records are collected pursuant to Iowa Code chapter 216A; the Omnibus Budget Reconciliation Act, PL 97-35 as amended to July 1, 2026; Juvenile Justice and Delinquency Prevention Act, PL 93-415 as amended to July 1, 2026; and the Victims Compensation and Assistance Act, PL 98-473 as amended to July 1, 2026. These records are confidential as outlined in Iowa Code section 22.7(18).

ab. Long-term and managed care ombudsman complaints. These records are collected pursuant to Iowa Code sections 135C.37 and 231.42. These records are confidential as outlined in Iowa Code sections 135C.37 and 231.42.

ac. Maternal and child health program. These records are collected pursuant to Iowa Code section 135.11(13). Records that contain medical information are confidential pursuant to Iowa Code section 22.7(2).

ad. Medicaid clients. These records are collected pursuant to Iowa Code section 249A.4. These records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §1396a(7) as amended to July 1, 2026; and 42 CFR §431.300 through 307 as amended to November 13, 1996.

ae. Medicaid provider information. These records are collected pursuant to Iowa Code section 249A.4. Some of these records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §1396a(7) as amended to July 1, 2026; and 42 CFR §431.300 through 307 as amended to November 13, 1996.

af. Newborn and infant hearing screening program. These records are collected pursuant to Iowa Code section 135.131. Information that identifies an individual patient is confidential as outlined in Iowa Code section 135.131.

ag. Nutrition and WIC (Special Supplemental Nutrition Program for Women, Infants and Children) program. These records are collected pursuant to Iowa Code section 135.11(1) and Chapter 17 of the federal Child Nutrition Act of 1966 as amended to January 5, 2023. These records are confidential as outlined in 7 CFR 246 as amended to July 1, 2026, and Iowa Code section 22.7(2).

ah. Radiological health program. These records are collected pursuant to Iowa Code chapters 136B and 136C. Certain records are confidential as outlined in rule 641—39.6(136C).

ai. Refugee health program. These records are collected pursuant to Iowa Code section 135.11(1) and Section 412(c)(3) of the federal Immigration and Naturalization Act as amended to July 1, 2026. Records that contain medical information are confidential pursuant to Iowa Code section 22.7(2).

aj. Refugee resettlement client records. These records are collected pursuant to Iowa Code section 217.1A. These records are confidential as outlined in Iowa Code section 217.30 and 45 CFR §400.27 as amended to March 22, 2000.

ak. Reportable diseases and other diseases and health conditions, including lead and other heavy metal poisonings. These records are collected pursuant to Iowa Code chapter 139A. Except for statistical reports, these records are confidential as required by Iowa Code chapter 139A.

al. Reportable sexually transmitted diseases or infections. These records are collected pursuant to Iowa Code chapter 139A. Except for statistical reports, these records are confidential as required by Iowa Code chapter 139A.

am. State institution resident records. These records are collected pursuant to Iowa Code section 218.1. These records are confidential as outlined in Iowa Code sections 218.22, 229.24 and 229.25.

an. State supplementary assistance clients. These records are collected pursuant to Iowa Code chapter 249. Some of these records are confidential as outlined in Iowa Code section 217.30.

ao. Substance use client records. These records are collected pursuant to Iowa Code chapters 125 and 218 and sections 234.6 and 249A.4. These records are confidential as outlined in Iowa Code section 125.93; 42 U.S.C. §29dd-2 and ee.3 as amended to January 1, 2024; 42 CFR Part 2 as amended to April 16, 2024; and 38 U.S.C. §4132 as amended to July 1, 2026.

ap. Substance use program licensing complaints. These records are collected pursuant to Iowa Code chapter 125. Certain information in these records may be confidential as outlined in Iowa Code section 22.7(2) and 22.7(18).

aq. Title IV-E foster care and adoption assistance client files. These records are collected pursuant to Iowa Code sections 217.1A and 600.17 through 600.22. These records are confidential as outlined in Iowa Code section 217.30; 42 U.S.C. §671(a)(8) as amended to July 1, 2026; and 45 CFR §1355.30(1) as amended to January 20, 2016.

ar. Veterinary public health. These records are collected pursuant to Iowa Code chapter 139A. Certain medical information in these records may be confidential as outlined in Iowa Code chapter 139A.

as. Vital records. These records are collected pursuant to Iowa Code chapter 144, including records of births, deaths, fetal deaths, adoptions, marriages, divorces, annulments and related data and correspondence. These records are confidential as outlined in Iowa Code section 144.43.

2505.9(3) Other restricted data contained in agency client records include the following.

a. Department of revenue information. These records are collected pursuant to Iowa Code sections 252B.5 and 252B.9. These records are confidential as outlined in Iowa Code sections 421.17 and 422.20(1).

b. Department of workforce development information. These records are collected pursuant to Iowa Code chapters 239B and 249A and section 252B.9. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §503(d) and (e) as amended to July 1, 2026.

c. Income and eligibility verification system. These records are collected pursuant to Iowa Code chapters 239B and 249A and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §1230b-7 as amended to July 1, 2026.

d. Department of public safety information. These records are collected pursuant to Iowa Code sections 237.8, 237A.5 and 252B.9. These records are confidential as outlined in Iowa Code sections 692.2, 692.3, 692.8 and 692.18.

e. Federal tax return information. These records are collected pursuant to Iowa Code chapters 239B, 249A and 252B and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 422.20(2) and 26 U.S.C. §6103 as amended to July 1, 2026.

f. Juvenile court information. These records are collected pursuant to Iowa Code chapter 232 and section 234.6. These records are confidential as outlined in Iowa Code sections 232.48, 232.97 and 232.147 through 232.151.

g. Peer review organization. These records are collected pursuant to Iowa Code section 249A.4. These records are confidential as outlined in Iowa Code section 217.30 and 42 U.S.C. §1320c-9 as amended to July 1, 2026.

h. United States Department of Health and Human Services information. These records are collected pursuant to Iowa Code chapters 239B, 249, 249A and 252B and sections 217.1A and 234.6. These records are confidential as outlined in Iowa Code section 217.30 and 42 CFR Part 401.134(c) as amended to October 1, 2002.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

These rules are intended to implement Iowa Code chapters 17A, 22, 135, 217, 228, and 252G and the Health Insurance Portability and Accountability Act of 1996 as amended to July 1, 2026.

[Filed Emergency ARC 0300D, IAB 5/27/26, effective 7/1/26]

CHAPTER 2506
CONTESTED CASES

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

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapters are below.
[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.2(17A) Definitions.

"Enrollee" means any applicant for or recipient of benefits or services provided by a program administered by the agency or on the agency's behalf.

"Good cause," for purposes of this chapter, has the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

"Household" means the same as defined in 7 CFR §273.1 as amended to July 1, 2026.

"Intentional program violation" means the same as established in 7 CFR §273.16 as amended to August 1, 2024.

"Medicaid" means Iowa's medical assistance program administered under Iowa Code chapter 249A.

"Party-in-interest" refers to the party, including enrollees, whose rights or obligations are the subject of a contested case hearing under this chapter. Parties-in-interest may or may not be the appellant.
[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.3(17A) Time obligations.

2506.3(1) In computing any time period specified in this chapter, the period:

a. Excludes the day of the event that triggers the period;

b. Includes every day of the time period (including Saturdays, Sundays, and holidays on which the agency is closed); and

c. Includes the last day of the period, but if the last day is a Saturday, Sunday, or a legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.
[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.4(17A) Electronic requests for contested case proceeding.

2506.4(3) *When a contested case hearing will be granted.* A person will be granted a contested case hearing if the party-in-interest fulfills all the following requirements:

a. The party-in-interest is entitled to a contested case hearing;

b. The party-in-interest has an ongoing, specific and personal interest in the outcome of the contested case hearing; and

c. The party-in-interest meets all the other requirements contained in these rules.

2506.4(4) *When a contested case hearing will not be granted.* A contested case hearing will not be granted when one of the following issues is appealed:

a. Patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders as amended to July 1, 2026.

b. Children have been removed from or placed in a specific foster care setting or preadoptive placement.

c. A final decision from a previous hearing with a presiding officer has been implemented.

d. A request for a waiver of administrative rule has been denied.

2506.4(5) *Exhaustion of remedies.* A person will only be granted a contested case hearing if the person has exhausted all other appeal remedies available. A person should refer to program-specific provisions for the appropriate procedures applicable to the specific program.

2506.4(6) *Exception for requesting a contested case proceeding hearing for Supplemental Nutrition Assistance Program (SNAP) and Medicaid appeals.* A person entitled to a contested case or hearing for Medicaid and SNAP appeals may request it:

a. By submitting an electronic request through the agency's website;
b. By telephone;
c. By mail;
d. In person; or
e. Through other commonly available electronic means (such as email).

2506.4(7) *Time to file appeals.* For all requests for contested case hearing, and unless federal or state law provides otherwise, the person must file the request for contested case hearing on or before the thirtieth day following the date of notice of the action being appealed. If such an appeal is made more than 30 days, but less than 90 days, after the date of notice, the director or director's designee may, at the director's or designee's sole discretion, allow a contested case hearing if the delay was for good cause, substantiated by the person.

2506.4(8) *Acceptance or denial of appeal.* The agency will determine with reasonable promptness whether the person who has filed the appeal is entitled to a contested case hearing. If a request is accepted, the agency will designate the issues. If a request is denied, the agency will provide written notice of and the reasons for the denial. On or before the thirtieth day following the denial, the person requesting the appeal may provide additional information related to the person's asserted right to a contested case hearing and request reconsideration of the denial.

2506.4(9) *Designation of issues.*

a. Initial designation. The issues initially designated by the agency will be certified to the department of inspections, appeals, and licensing (DIAL) and be identified in the notice of hearing.

b. Additional designation of issues. If any person believes additional issues should be designated, the person shall identify the additional issues within the following timelines. The presiding officer shall determine whether all issues have properly been preserved.

(1) Child abuse and dependent adult abuse registry appeals. For a child abuse and dependent adult abuse registry appeal, the person shall identify additional issues at least 30 days before the date of hearing.

(2) Appeals set on or before the fifteenth day following the notice of hearing. If the hearing is on or before the fifteenth day following the date of the notice of hearing, the person shall identify any additional issues at the hearing.

(3) All other appeals. For all other appeals not identified in this paragraph, the person shall identify the additional issues on or before the fifteenth day following the date of the notice of hearing.

2506.4(10) *Agency responsibilities on SNAP hearing requests.* Upon request, the agency will make available without charge the specific materials necessary for a household or its representative to determine whether a hearing should be requested or to prepare for a hearing. If the person making the request speaks a language other than English and the agency is required by 7 CFR §272.4(c)(3) as amended to July 1, 2026, to provide bilingual staff or interpreters who speak the appropriate language, the agency will ensure that the hearing procedures are verbally explained in that language. Upon request, the agency will also help a household with its hearing request. If a household makes an oral request for a hearing, the agency will complete the procedures necessary to start the hearing process. Households will be advised of any legal services available that can provide representation at the hearing. This rule does not preclude the provision of these services in all other appeals.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.5(17A) Notice of hearing.

2506.5(2) *Contents.* The notice of hearing must state:

a. The time, place, and nature of the hearing;
b. The legal authority and jurisdiction under which the hearing is to be held;
c. The particular sections of the statutes and rules involved;
d. The procedural rules governing conduct of the contested case proceeding;
e. The procedural rules governing informal settlement;
f. The identity of the presiding officer, if known, or, if not, a description of who will serve as presiding officer; and
g. The deadline to request under Iowa Code section 17A.11 and rule 441—2506.6(17A), that the presiding officer be an administrative law judge (ALJ).

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.6(17A) Presiding officer.

2506.6(1) If an ALJ is not assigned, any party that wants an ALJ employed by DIAL to serve as the presiding officer must file a request. The deadline for that request is 20 days after service of a notice of hearing that identifies someone other than an ALJ as the presiding officer.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.10(17A) Consolidation—severance.

2506.10(3) *Medicaid member appeals.* Notwithstanding subrule 2506.10(1), for Medicaid member appeals, the agency and the presiding officer acting on behalf of the agency:

a. May respond to a series of individual requests for hearing by conducting a single group hearing;

b. May consolidate hearings only in cases in which the sole issue involved is one of federal or state law or policy;

c. Must follow the policies of 42 CFR, Chapter IV, Subchapter C, Part 431, Subpart E, as amended to July 1, 2026;

d. Must permit each person to present the individual's own case or be represented by the individual's authorized representative.

2506.10(4) *SNAP appeals.* The agency may respond to a series of individual requests for hearings by conducting a single group hearing. The agency may consolidate only cases where individual issues of fact are not disputed and where related issues of state or federal law, regulation, or policy are the sole issues being raised. In all group hearings, the regulations governing individual hearings must be followed. Each individual household shall be permitted to present its own case or have its case presented by a representative.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.11(17A) Pleadings. This rule is not adopted.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.12(17A) Electronic service and filing of pleadings and other papers.

2506.12(1) *Filing and service electronically.* Except as provided in subrule 2506.4(6), every pleading, motion, document, or other paper that is filed or served shall be executed electronically whenever possible. Filing or service by a nonelectronic method can only be upon a showing to the presiding officer of undue hardship to use electronic mail.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.18(17A) Withdrawals.

2506.18(1) *Medicaid appeal withdrawals.* For Medicaid member appeals, the agency must record the individual's statement and telephonic signature for telephonic hearing withdrawals. For telephonic, online and other electronic withdrawals, the agency must send the affected person written confirmation, via regular mail or electronic notification in accordance with the individual's election.

2506.18(2) *SNAP appeal withdrawals.* For oral withdrawal of SNAP appeals, the agency must provide a written notice to the household within ten days of the household's request confirming the withdrawal request and providing the household with an opportunity to request a hearing. The written notice must advise the household it has ten days from the date it receives the notice to advise the agency of its desire to request, or reinstate, the hearing. If the household timely advises the agency that it wishes to reinstate the fair hearing, the agency must provide the household with a fair hearing, within the time frames specified in 7 CFR §273.15(c) as amended to July 1, 2026, and beginning the date the household advises the agency that it wishes to reinstate its request. The agency must reinstate a fair hearing as requested from a household at least once. The agency must not deny a household's request for a fair hearing if the household is aggrieved by an agency action that differs from the reinstated action.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.20(17A) Hearing procedures.

2506.20(3) *Representation.* Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, limited-liability companies, and associations may be represented by any member, officer, director, or duly authorized agent. The agency may be represented by agency employees or employees of an agency contractor. Any party may be represented by an attorney, an authorized representative appointed pursuant to rule 441—76.9(249A), an authorized representative appointed pursuant to subrule 2506.20(8), or another person authorized by law. An attorney admitted pro hoc vice in accordance with Iowa Court Rules to practice in an agency administrative action in accordance with Iowa Court Rule 31.14 is obligated to have an in-state attorney present at every interaction with the presiding officer.

2506.20(8) *Authorized representatives.*

a. Regulations. The provisions of this subrule only apply to the extent the standards expressed in this subrule are not in conflict with other state or federal law.

b. Designation of authority. Legally recognized delegations of authority, such as guardianships, applicable designations of power of attorney, or similar designations, shall be sufficient for a delegate to serve as authorized representative under this chapter. A person who is not designated a legally recognized delegation of authority but who otherwise seeks to act as an authorized representative for a person in an appeal under this chapter shall provide a written, signed designation of authority to the agency with the request for appeal. The designation must provide the scope of the representation, applicable waivers for the release of confidential information, and any temporal or other limitations on the scope of representation. An authorized representative of a party-in-interest only represents the party-in-interest and has no independent right to appeal by virtue of the authorized representative's representation.

c. Written designation. For a person other than an attorney seeking to act as an authorized representative of a party-in-interest in a Medicaid managed care appeal, the authorized representative's written designation of authority pursuant to paragraph 2506.20(8)*"b"* shall be on an authorized representative form prescribed by the agency. This form is required for all managed care appeals, including those handled through the expedited appeals process. Failure to provide the form or legal documentation may result in denial of the appeal request.

2506.20(9) *Appearance by attorney.* Legal counsel appearing on behalf of any person in a proceeding under this chapter shall enter an appropriate written appearance.

2506.20(10) *Closed to public.* Contested case hearings are closed to the public, and unless otherwise provided by state or federal law, only the parties, their representatives, permissible intervenors, and witnesses may be present for a contested case hearing in the absence of mutual agreement of the parties.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.27(17A) Appeals and review.

2506.27(1) *Appeal by party.*

a. Unless otherwise prohibited by law, any adversely affected party may appeal a proposed decision to the agency within 30 days after the decision is issued.

b. A managed care organization (MCO) appealing a proposed decision reversing an adverse benefit determination shall request the director's review within 72 hours from the date it received notice of the proposed decision.

c. In Medicaid and SNAP appeals, an appeal of a proposed decision to the agency shall be made within 14 days after the date the decision is issued.

d. In appeals from a child abuse assessment under Iowa Code section 235A.19, an appeal of a proposed decision to the agency shall be made within ten days after the date the decision is issued.

e. In WIC appeals, an appeal of a proposed decision to the agency shall be made within ten days after the date the decision is issued.

2506.27(2) *Review.* Unless otherwise prohibited by law, the agency may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

2506.27(7) *Limited record.* The director's review on appeal shall be limited to the issues and record before the contested case hearing presiding officer.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.32(17A) Timelines for contested case hearings.

2506.32(1) *Medical assistance.* In cases involving the determination of medical assistance, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 42 CFR §431.244(f) as amended to December 8, 2021.

2506.32(2) *Community spouse resource allowance.* In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

2506.32(3) *SNAP.* In cases involving SNAP, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 7 CFR §273.15(c) as amended to July 1, 2026.

2506.32(4) *WIC.* In cases involving WIC, the hearing shall be held within three weeks from the date the request for hearing was received.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.33(17A) Medical assistance expedited review.

2506.33(1) *Expedited review criteria.* An appellant to a medical assistance appeal may, at any time, file with the agency a request for expedited review of the appeal. Expedited review shall be granted pursuant to 42 CFR §438.410 as amended to August 1, 2024, for an MCO appeal or 42 CFR §431.224 as amended to August 1, 2024, for a non-MCO appeal.

2506.33(2) *Managed care expedited proceedings.*

a. If the appellant is granted an expedited review, all subsequent proceedings shall also be expedited without an additional request if the appeal request indicates that the MCO appeal was expedited and provides the basis for expedited relief.

b. When review is expedited pursuant to this rule, the presiding officer shall issue a proposed decision as expeditiously as the enrollee's health condition requires but no later than three working days after the agency receives from the MCO the case file and information for any appeal of a denial of a service that, as indicated by the MCO:

(1) Meets the criteria for expedited resolution but was not resolved within the time frame for expedited resolution; or

(2) Was resolved within the time frame for expedited resolution but reached a decision wholly or partially adverse to the enrollee.

2506.33(3) *Medicaid eligibility or preadmission and annual resident review expedited proceedings.* For expedited appeals related to Medicaid eligibility or preadmission and annual resident review requirements, the presiding officer shall issue a proposed decision as expeditiously as possible but no later than seven working days after the agency receives a request for an expedited fair hearing.

2506.33(4) *Medicaid-covered benefits or services expedited proceedings.* For expedited appeals related to Medicaid-covered benefits or services, the presiding officer shall issue a proposed decision as expeditiously as possible but no later than provided in paragraph 2506.33(2)*"b."*

2506.33(5) *Final decision for expedited proceeding.* The agency will issue its final decision in accordance with this rule, except as provided by subrule 2506.33(2).

2506.33(6) *Notification if expedited relief is granted or denied.* The agency will notify the appellant as expeditiously as possible whether the request for expedited relief is granted or denied. Such notice will be provided orally or through electronic means to the extent consistent with federal and state law. If oral notice is provided, the agency will follow up with written notice, which may be through electronic means to the extent consistent with federal and state law.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.34(17A) SNAP administrative disqualification hearings. An intentional program violation is determined through a SNAP administrative disqualification hearing; through a court conviction; or through individual signs and returns a form prescribed by the agency, which may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both in accordance with the procedures outlined in this rule and in 7 CFR §273.16(e) and (f) as amended to December 8, 2021.

2506.34(1) When a case is referred for an administrative disqualification hearing, the agency will mail written notification to the individual that the individual can waive the right to an administrative disqualification hearing by signing and returning a waiver of right to an administrative disqualification hearing.

2506.34(2) By signing a waiver of right to an administrative disqualification hearing, the individual:

a. Waives the right to an administrative disqualification hearing;

b. Consents to the SNAP disqualification period designated in the waiver of right to an administrative disqualification hearing and a reduction of benefits for the period of disqualification; and

c. Acknowledges that remaining household members, if any, may be held responsible for repayment of the resulting claim.

2506.34(3) An administrative disqualification hearing will be scheduled if the individual does not sign and mail or fax the waiver of right to an administrative disqualification hearing to the agency within ten days of receipt of the written notification stating the individual can waive the right to an administrative disqualification hearing. The date on which the written notification is received is considered to be five days after the date on the notification unless the individual shows the notification was not received within the five-day period.

2506.34(4) An individual who waives the right to an administrative disqualification hearing will be subject to the same penalties as an individual found to have committed an intentional program violation in an administrative disqualification hearing.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

441—2506.35(17A) Continuation and reinstatement of benefits.

2506.35(1) *Programs for which no federal or state law applies.* For all assistance programs for which there is no contravening federal or state law, benefits or services shall not be suspended, reduced, restricted, or discontinued, nor shall a license, registration, certification, approval, or accreditation be revoked or other adverse action taken pending a final decision when:

a. An appeal is filed before the effective date of the intended action; or

b. The appellant requests a hearing within ten days of receipt of a notice to suspend, reduce, restrict, or discontinue benefits or services. The date on which the notice is received is considered to be five days after the date on the notice unless the appellant shows the notice was not received within the five-day period.

2506.35(2) *Sole issue is state or federal law or policy.* Benefits or services continued pursuant to subrule 2506.35(1) may be suspended, reduced, restricted, or discontinued if the presiding officer determines at the contested case hearing that the sole issue is one of state or federal law or policy and the agency has notified the enrollee in writing that services are to be suspended, reduced, restricted, or discontinued pending the proposed decision.

2506.35(3) *Recoup cost of services or benefits.* The agency or MCO may recoup the cost of benefits or services provided pursuant to this chapter and 7—Chapter 2506 if the adverse action appealed from is affirmed, consistent with state and federal law.

[**ARC 0300D**, IAB 5/27/26, effective 7/1/26]

[Filed Emergency ARC 0300D, IAB 5/27/26, effective 7/1/26]