*State of Iowa*

# Iowa Administrative Code Supplement

Biweekly
March 10, 1999

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

In addition to the changes adopted by agencies, the replacement pages may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(4); an effective date delay imposed by the ARRC pursuant to section 17A.4(5) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(6); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index and for the preliminary sections of the IAC: General Information about the IAC, Chapter 17A of the Code of Iowa, Style and Format of Rules, Table of Rules Implementing Statutes, and Uniform Rules on Agency Procedure.

# INSTRUCTIONS

FOR

Updating Iowa Administrative Code
with Biweekly Supplement

NOTE: Please review the "Preface" for both the Iowa Administrative Code and Biweekly Supplement and follow carefully the updating instructions.

The boldface entries in the left-hand column of the updating instructions correspond to the tab sections in the IAC Binders.

Obsolete pages of IAC are listed in the column headed "Remove Old Pages." New and replacement pages in this Supplement are listed in the column headed "Insert New Pages." It is important to follow instructions in both columns.

**Editor's telephone: (515)281-3355 or (515)281-8157**
**Fax: (515)281-4424**

## UPDATING INSTRUCTIONS
## March 10, 1999, Biweekly Supplement

[Previous Supplement dated 2/24/99]

IOWA ADMINISTRATIVE CODE

| | Remove Old Pages* | Insert New Pages |
|---|---|---|
| **First Volume—General Information** (Gray Tab) | p. 1, 2<br>p. 5—8<br>p. 11, 12<br>p. 15, 16 | p. 1, 2<br>p. 5—8<br>p. 11, 12<br>p. 15, 16 |
| **First Volume—Uniform Rules on Agency Procedure** (Green Tab) | Page 7, 8<br>Page 27, 28 | Page 7, 8<br>Page 27, 28 |
| **AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]** | Analysis, p. 1, 2<br>Ch 22, p. 1, 2 | Analysis, p. 1, 2<br>Ch 22, p. 1, 2 |
| **Criminal and Juvenile Justice Planning Division[428]** | Analysis, p. 1 | Analysis, p. 1<br>Ch 5, p. 1—Ch 5, p. 7 |

*It is recommended that "Old Pages" be retained indefinitely in a place of your choice. They may prove helpful in tracing the history of a rule.

| | Remove Old Pages* | Insert New Pages |
|---|---|---|
| **HUMAN SERVICES DEPARTMENT[441]** | Ch 51, p. 1—Ch 52, p. 4 | Ch 51, p. 1—Ch 52, p. 4 |
| | Ch 75, p. 23, 24 | Ch 75, p. 23, 24 |
| | Ch 75, p. 41, 42 | Ch 75, p. 41, 42 |
| | Ch 75, p. 91 | Ch 75, p. 91, 92 |
| | Ch 77, p. 5—Ch 77, p. 12 | Ch 77, p. 5—Ch 77, p. 12 |
| | Ch 77, p. 27, 28 | Ch 77, p. 27, 28 |
| | Ch 77, p. 31, 32 | Ch 77, p. 31, 32 |
| | Ch 78, p. 45, 46 | Ch 78, p. 45, 46 |
| | Ch 78, p. 91—Ch 78, p. 94 | Ch 78, p. 91—Ch 78, p. 94 |
| | Ch 78, p. 101—Ch 78, p. 106 | Ch 78, p. 101—Ch 78, p. 106 |
| | Ch 78, p. 111—Ch 78, p. 114 | Ch 78, p. 111—Ch 78, p. 114 |
| | Ch 78, p. 119—Ch 78, p. 124 | Ch 78, p. 119—Ch 78, p. 124 |
| | Ch 78, p. 131, 132 | Ch 78, p. 131, 132 |
| | Ch 79, p. 3—Ch 79, p. 10 | Ch 79, p. 3—Ch 79, p. 10 |
| | Ch 79, p. 61, 62 | Ch 79, p. 61, 62 |
| | Ch 83, p. 1—Ch 83, p. 4 | Ch 83, p. 1—Ch 83, p. 4 |
| | Ch 83, p. 7, 8 | Ch 83, p. 7, 8 |
| | Ch 83, p. 11, 12 | Ch 83, p. 11, 12 |
| | Ch 83, p. 17—Ch 83, p. 20 | Ch 83, p. 17—Ch 83, p. 20 |
| | Ch 83, p. 27, 28 | Ch 83, p. 27, 28 |
| | Ch 83, p. 31, 32 | Ch 83, p. 31, 32 |
| | Ch 83, p. 41, 42 | Ch 83, p. 41, 42 |
| | Ch 86, p. 1, 2 | Ch 86, p. 1, 2 |
| | Ch 86, p. 17—Ch 86, p. 20 | Ch 86, p. 17—Ch 86, p. 20 |
| | Ch 170, p. 3, 4 | Ch 170, p. 3, 4 |
| | Ch 170, p. 7, 8 | Ch 170, p. 7, 8 |
| | Ch 177, p. 1—Ch 177, p. 6 | Ch 177, p. 1—Ch 177, p. 6 |
| **Natural Resource Commission[571]** | Analysis, p. 1—Analysis, p. 6 | Analysis, p. 1—Analysis, p. 6 |
| | Ch 15, p. 9—Ch 15, p. 15 | Ch 15, p. 9—Ch 15, p. 16 |
| | Ch 29, p. 1—Ch 29, p. 3 | Ch 29, p. 1—Ch 29, p. 3 |
| | Ch 39, p. 1 | Ch 39, p. 1 |
| | Ch 94, p. 1—Ch 94, p. 5 | Ch 94, p. 1—Ch 94, p. 5 |
| **Professional Licensure Division[645]** | Analysis, p. 5, 6 | Analysis, p. 5, 6 |
| | Ch 60, p. 9—Ch 60, p. 11 | Ch 60, p. 9—Ch 60, p. 11 |
| | Ch 63, p. 1—Ch 64, p. 3 | Ch 63, p. 1—Ch 64, p. 4 |
| **Pharmacy Examiners Board[657]** | Analysis, p. 5—Analysis, p. 7 | Analysis, p. 5—Analysis, p. 7 |
| | Ch 6, p. 1—Ch 6, p. 5 | Ch 6, p. 1—Ch 6, p. 6 |
| | Ch 7, p. 3—Ch 7, p. 7 | Ch 7, p. 3—Ch 7, p. 8 |
| | Ch 15, p. 3—Ch 15, p. 5 | Ch 15, p. 3—Ch 15, p. 5 |
| | Ch 19, p. 1, 2 | Ch 19, p. 1—Ch 19, p. 3 |
| | Ch 22, p. 3—Ch 25, p. 3 | Ch 22, p. 3—Ch 25, p. 2 |
| | | Ch 31, p. 1, 2 |

*It is recommended that "Old Pages" be retained indefinitely in a place of your choice. They may prove helpful in tracing the history of a rule.

| | Remove Old Pages* | Insert New Pages |
|---|---|---|
| REVENUE AND FINANCE DEPARTMENT[701] | Analysis, p. 21, 22 | Analysis, p. 21, 22 |
| | Ch 71, p. 1—Ch 71, p. 4 | Ch 71, p. 1—Ch 71, p. 4 |
| | Ch 71, p. 23 | Ch 71, p. 23 |
| TRANSPORTATION DEPARTMENT[761] | Analysis, p. 11, 12 | Analysis, p. 11, 12 |
| | Ch 452, p. 1—Ch 453, p. 1 | Ch 452, p. 1—Ch 454, p. 1 |
| | Ch 520, p. 1—Ch 520, p. 3 | Ch 520, p. 1—Ch 520, p. 3 |
| | Ch 620, p. 3—Ch 620, p. 5 | Ch 620, p. 3—Ch 620, p. 5 |
| Index Volume | "F" Tab, p. 11—31 | "F" Tab, p. 11—31 |

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## INTRODUCTION

The philosophy and mechanics of the Iowa rule-making process are set out in Iowa Code sections 17A.1 through 17A.8, with additional provisions found in Iowa Code sections 2B.1, 2B.5, 2B.13, 2B.21, 3.6, 7.17, 17A.31 through 17A.33, and 25B.6.

The information which follows is intended to serve as a guide for rule making.

Inquiries may be directed to:

Iowa Administrative Code Division
Lucas State Office Building, First Floor
Des Moines, Iowa 50319

Telephone: (515)281-3355; 281-8157

Fax: (515)281-4424

## SUBSCRIPTION INFORMATION

### Iowa Administrative Code

The Iowa Administrative Code and Supplements are sold in complete sets and by subscription basis only. Annual subscriptions for the Supplement (replacement pages) expire on June 30 of each year.

Prices for the Iowa Administrative Code and its Supplements are as follows:

**Iowa Administrative Code** — $1,119.00 plus $54.95 sales tax
(Price includes 22 volumes of rules and index, plus a one-year subscription to the Iowa Administrative Code Supplement and the Iowa Administrative Bulletin.)

Additional or replacement binders may be purchased for $10.90 plus $.55 sales tax.

**Iowa Administrative Code Supplement** — $393.50 plus $19.68 sales tax
(Subscription expires June 30, 1999)

### Iowa Administrative Bulletin

The Iowa Administrative Bulletin may be purchased by subscription or single copy. Subscriptions expire on June 30 of each year. Subscriptions must be paid in advance and are prorated quarterly as follows:

| | | |
|---|---|---|
| First quarter | July 1, 1998, to June 30, 1999 | $244.10 plus $12.21 sales tax |
| Second quarter | October 1, 1998, to June 30, 1999 | $185.00 plus $ 9.25 sales tax |
| Third quarter | January 1, 1999, to June 30, 1999 | $125.00 plus $ 6.25 sales tax |
| Fourth quarter | April 1, 1999, to June 30, 1999 | $ 65.00 plus $ 3.25 sales tax |

Single copies may be purchased for $19.00 plus $.95 sales tax. Back issues may be purchased if the issues are available.

**All checks should be made payable to Iowa State Printing Division. Send all inquires and subscription orders to:**

**Customer Service Center**
**Department of General Services**
**Hoover State Office Building, Level A**
**Des Moines, IA 50319**
**Telephone: (515)242-5120**

## ADMINISTRATIVE RULES COORDINATOR

*Iowa Code sections 7.17, 17A.5, 17A.6*

The Administrative Rules Coordinator (ARC) is a position established within the Governor's office. The responsibility of the coordinator is to receive all notices and filings made pursuant to the rule-making provisions of the Iowa Administrative Procedure Act (Iowa Code chapter 17A).

Other duties include the following:

1. Establish, in consultation with the Administrative Code Editor, the uniform style and form by which an agency prepares and submits a document; return agency filings not in compliance and review all submitted rules for proper style and form.

2. Prescribe a uniform numbering system for rules.

3. Assign an ARC Identification Number to each rule-making document submitted by an agency for publication in the Iowa Administrative Bulletin.

4. Require a specific form to be attached to each rule-making document. Sample forms are reproduced in "Style and Form" herein following the Red Tab.

| | |
|---|---|
| Notice of Intended Action | Form A |
| Adopted Rule | Form B |
| Emergency | Form C |

5. Direct the Administrative Code Editor to publish the Iowa Administrative Code (IAC) Supplement and the Iowa Administrative Bulletin (IAB). The ARC receives all proposed and adopted rules. These documents are logged in and forwarded to the Editor for publication in the Iowa Administrative Bulletin and Iowa Administrative Code Supplement.

6. Maintain a permanent register of the rules and be the depository for all rules submitted after July 1, 1978. Prior to that time, the Secretary of State was the official depository.

7. Make legal recommendations to the Governor regarding power of objection and rescission of any adopted rule.

8. Provide technical assistance to agencies as they draft rules.

9. Serve as the Governor's ex officio representative to the Administrative Rules Review Committee.

Inquiries may be directed to Brian Gentry or Stephanie Pickens, Capitol, Room 11, Des Moines, Iowa 50319. Telephone (515)281-0182; fax (515)281-6611.

# IOWA ADMINISTRATIVE CODE EDITOR

*Iowa Code chapters 2B and 17A*

The Administrative Code Editor, appointed by the Director of the Legislative Service Bureau subject to the approval of the Legislative Council, has the primary responsibility for the technical editing, preparation and publishing of the Iowa Administrative Code (IAC) and the Iowa Administrative Bulletin (IAB) with the assistance of the Administrative Code Division, the Administrative Rules Coordinator and the Printing Division of the Department of General Services. The Administrative Code Division also edits and publishes the Iowa Court Rules and the State Roster and provides assistance to agencies with respect to style and format.

The Administrative Code Editor or a designee serves as Secretary to the Administrative Rules Review Committee (ARRC), prepares minutes of ARRC meetings and works with the Committee Counsel in preparation of meeting agenda.

Inquiries may be directed to Kathleen Bates, Administrative Code Editor, Lucas State Office Building, First Floor, Des Moines, Iowa 50319. Telephone (515)281-3355; fax 281-4424.

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# ATTORNEY GENERAL

*Iowa Code sections 13.2, 17A.4(2), 17A.4(4)*

The Attorney General's duties which may affect rule making include the following:

1. Advise state agencies concerning legal issues raised during rule making. State agencies may seek legal advice concerning procedure, statutory authority, and substantive legal questions.

2. Render opinions on questions of law. Attorney General's opinions provide a source of law to guide public officers. In the event that litigation develops, issued opinions receive respectful consideration by the courts.

3. Object to emergency rules which are adopted without notice or comment or which are made effective immediately. If the Attorney General objects on this basis, the rule ceases to be effective 180 days after the filing of the objection. [17A.4(2)]

4. Object to any rule on the ground that it is unreasonable, arbitrary or capricious, or beyond the agency's authority. An objection on this ground shifts the burden to the agency to establish that the rule is valid, and the agency will be liable for attorneys' fees and costs if the rule is found invalid on judicial review. [17A.4(4)]

5. Defend agency rules when challenged on judicial review.

# ADMINISTRATIVE RULES REVIEW COMMITTEE

*Iowa Code section 17A.8*

The Administrative Rules Review Committee (ARRC) is bipartisan and is composed of five members of the House of Representatives and five members of the Senate.

Iowa Code section 17A.8(5) requires that a regular Committee meeting be held on the second Tuesday of each month. However, a special meeting may be called by the Chair or Co-chair at any place in the state and at any time.

The Committee meets for the purpose of selectively reviewing rules, whether the rule is proposed or is in effect. Meetings are open to the public and any interested person may appear and present testimony. The Committee may require a representative of an agency whose rule or proposed rule is under consideration to attend a Committee meeting.

The Committee may refer a rule to the Speaker of the House and President of the Senate for review during the next regular session of the General Assembly. The Speaker and President must refer the rule to the appropriate standing committee of the General Assembly.

If the Committee finds objection to a rule, it may, in writing, notify the agency of the objection. In any subsequent court proceeding, the burden is on the agency to prove the rule is reasonable. The Committee may also recommend that the Legislature adopt a law to supersede the rule.

Upon a two-thirds vote of its members, the Committee may delay the effective date of a rule 70 days beyond its normal effective date if further time is needed to study and examine the rule.

Upon a two-thirds vote, the Committee may delay the effective date of a rule until the adjournment of the next regular session of the General Assembly. [17A.8(9)]

In the event the Committee has reason to believe a rule making will have an impact on small business, the Committee may request the agency to issue a Regulatory Flexibility Analysis in accordance with Iowa Code section 17A.31(3).

Any two members of the Committee may request an Economic Impact Statement. The agency must analyze the impact of the proposed rules and prepare an estimate to be published in the Iowa Administrative Bulletin prior to adoption of the rules. [17A.4(1)*"c"*]

The General Assembly by Joint Resolution may nullify an administrative rule. [Ia. Const., Art III §40] The Resolution shall be published in the Iowa Administrative Bulletin.

The Committee may employ legal and technical staff to assist in its work. Those specific duties include preparation of memoranda on potentially controversial rules and setting time, place and agenda for ARRC meetings. [17A.8(10)]

During the Legislative Session, the Committee finds it increasingly difficult to devote the necessary time for thorough study of massive filings. The Committee has requested agencies to plan rule making so that the majority of administrative rules may be considered at times other than the months of February through May.

Inquiries may be directed to Joe Royce, Statehouse, Room 116A, Des Moines, Iowa 50319. Telephone (515)281-3084; fax (515)281-5995.

## ADMINISTRATIVE RULES REVIEW COMMITTEE

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EDITOR'S NOTE: Terms ending April 30, 1999.

# AGENCY IDENTIFICATION NUMBERS

"Umbrella" agencies and elected officials are set out below at the left-hand margin in capital letters. In the Iowa Administrative Code, these agencies are identified by yellow-tabbed divider sheets.

Divisions (e.g., boards, commissions, committees, councils and authorities) are indented and set out in lowercase type under their statutory "umbrellas." In the Iowa Administrative Code, these divisions are identified by green-tabbed divider sheets. In addition, Professional Licensing and Regulation Division[193] under the Commerce Department[181] "umbrella" has six autonomous agencies which are identified with purple-tabbed divider sheets.

Other autonomous agencies not statutorily assigned to an "umbrella" or division are included alphabetically in smaller capital letters at the left-hand margin. In the Iowa Administrative Code, these agencies are identified by orange-tabbed divider sheets.

The following list will be updated as changes occur:

AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]
- Agricultural Development Authority[25]
- Soil Conservation Division[27]

ATTORNEY GENERAL[61]

AUDITOR OF STATE[81]

BEEF INDUSTRY COUNCIL, IOWA[101]

BLIND, DEPARTMENT FOR THE[111]

CITIZENS' AIDE[141]

CIVIL RIGHTS COMMISSION[161]

COMMERCE DEPARTMENT[181]
- Alcoholic Beverages Division[185]
- Banking Division[187]
- Credit Union Division[189]
- Insurance Division[191]
- Professional Licensing and Regulation Division[193]
  - Accountancy Examining Board[193A]
  - Architectural Examining Board[193B]
  - Engineering and Land Surveying Examining Board[193C]
  - Landscape Architectural Examining Board[193D]
  - Real Estate Commission[193E]
  - Real Estate Appraiser Examining Board[193F]
- Savings and Loan Division[197]
- Utilities Division[199]

CORRECTIONS DEPARTMENT[201]
Parole Board[205]

CULTURAL AFFAIRS DEPARTMENT[221]
Arts Division[222]
Historical Division[223]

ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]
City Development Board[263]
Iowa Finance Authority[265]

EDUCATION DEPARTMENT[281]
Educational Examiners Board[282]
College Student Aid Commission[283]
Higher Education Loan Authority[284]
Iowa Advance Funding Authority[285]
Libraries and Information Services Division[286]
Public Broadcasting Division[288]
School Budget Review Committee[289]

EGG COUNCIL[301]

ELDER AFFAIRS DEPARTMENT[321]

EMPOWERMENT BOARD, IOWA[349]

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]

EXECUTIVE COUNCIL[361]

FAIR BOARD[371]

GENERAL SERVICES DEPARTMENT[401]

HUMAN INVESTMENT COUNCIL[417]

HUMAN RIGHTS DEPARTMENT[421]
Community Action Agencies Division[427]
Criminal and Juvenile Justice Planning Division[428]
Deaf Services Division[429]
Persons With Disabilities Division[431]
Latino Affairs Division[433]
Status of Blacks Division[434]
Status of Women Division[435]

## Schedule for Rule Making
## 1999

| NOTICE SUBMISSION DEADLINE | NOTICE PUB. DATE | HEARING OR COMMENTS 20 DAYS | FIRST POSSIBLE ADOPTION DATE 35 DAYS | ADOPTED FILING DEADLINE | ADOPTED PUB. DATE | FIRST POSSIBLE EFFECTIVE DATE | POSSIBLE EXPIRATION OF NOTICE 180 DAYS |
|---|---|---|---|---|---|---|---|
| Dec. 25 '98 | Jan. 13 '99 | Feb. 2 '99 | Feb. 17 '99 | Feb. 19 '99 | Mar. 10 '99 | Apr. 14 '99 | July 12 '99 |
| Jan. 8 | Jan. 27 | Feb. 16 | Mar. 3 | Mar. 5 | Mar. 24 | Apr. 28 | July 26 |
| Jan. 22 | Feb. 10 | Mar. 2 | Mar. 17 | Mar. 19 | Apr. 7 | May 12 | Aug. 9 |
| Feb. 5 | Feb. 24 | Mar. 16 | Mar. 31 | Apr. 2 | Apr. 21 | May 26 | Aug. 23 |
| Feb. 19 | Mar. 10 | Mar. 30 | Apr. 14 | Apr. 16 | May 5 | June 9 | Sept. 6 |
| Mar. 5 | Mar. 24 | Apr. 13 | Apr. 28 | Apr. 30 | May 19 | June 23 | Sept. 20 |
| Mar. 19 | Apr. 7 | Apr. 27 | May 12 | May 14 | June 2 | July 7 | Oct. 4 |
| Apr. 2 | Apr. 21 | May 11 | May 26 | May 28 | June 16 | July 21 | Oct. 18 |
| Apr. 16 | May 5 | May 25 | June 9 | June 11 | June 30 | Aug. 4 | Nov. 1 |
| Apr. 30 | May 19 | June 8 | June 23 | June 25 | July 14 | Aug. 18 | Nov. 15 |
| May 14 | June 2 | June 22 | July 7 | July 9 | July 28 | Sept. 1 | Nov. 29 |
| May 28 | June 16 | July 6 | July 21 | July 23 | Aug. 11 | Sept. 15 | Dec. 13 |
| June 11 | June 30 | July 20 | Aug. 4 | Aug. 6 | Aug. 25 | Sept. 29 | Dec. 27 |
| June 25 | July 14 | Aug. 3 | Aug. 18 | Aug. 20 | Sept. 8 | Oct. 13 | Jan. 10 '00 |
| July 9 | July 28 | Aug. 17 | Sept. 1 | Sept. 3 | Sept. 22 | Oct. 27 | Jan. 24 '00 |
| July 23 | Aug. 11 | Aug. 31 | Sept. 15 | Sept. 17 | Oct. 6 | Nov. 10 | Feb. 7 '00 |
| Aug. 6 | Aug. 25 | Sept. 14 | Sept. 29 | Oct. 1 | Oct. 20 | Nov. 24 | Feb. 21 '00 |
| Aug. 20 | Sept. 8 | Sept. 28 | Oct. 13 | Oct. 15 | Nov. 3 | Dec. 8 | Mar. 6 '00 |
| Sept. 3 | Sept. 22 | Oct. 12 | Oct. 27 | Oct. 29 | Nov. 17 | Dec. 22 | Mar. 20 '00 |
| Sept. 17 | Oct. 6 | Oct. 26 | Nov. 10 | Nov. 12 | Dec. 1 | Jan. 5 '00 | Apr. 3 '00 |
| Oct. 1 | Oct. 20 | Nov. 9 | Nov. 24 | Nov. 26 | Dec. 15 | Jan. 19 '00 | Apr. 17 '00 |
| Oct. 15 | Nov. 3 | Nov. 23 | Dec. 8 | Dec. 10 | Dec. 29 | Feb. 2 '00 | May 1 '00 |
| Oct. 29 | Nov. 17 | Dec. 7 | Dec. 22 | Dec. 24 | Jan. 12 '00 | Feb. 16 '00 | May 15 '00 |
| Nov. 12 | Dec. 1 | Dec. 21 | Jan. 5 '00 | Jan. 7 '00 | Jan. 26 '00 | Mar. 1 '00 | May 29 '00 |
| Nov. 26 | Dec. 15 | Jan. 4 '00 | Jan. 19 '00 | Jan. 21 '00 | Feb. 9 '00 | Mar. 15 '00 | June 12 '00 |
| Dec. 10 | Dec. 29 | Jan. 18 '00 | Feb. 2 '00 | Feb. 4 '00 | Feb. 23 '00 | Mar. 29 '00 | June 26 '00 |
| Dec. 24 | Jan. 12 '00 | Feb. 1 '00 | Feb. 16 '00 | Feb. 18 '00 | Mar. 8 '00 | Apr. 12 '00 | July 10 '00 |
| Jan. 7 '00 | Jan. 26 '00 | Feb. 15 '00 | Mar. 1 '00 | Mar. 3 '00 | Mar. 22 '00 | Apr. 26 '00 | July 24 '00 |

**PLEASE NOTE:**

Rules will not be accepted after **12 o'clock noon** on the Friday filing deadline days unless prior approval has been received from the Administrative Rules Coordinator's office.

If the filing deadline falls on a legal holiday, submissions made on the following Monday will be accepted.

# GUIDE FOR TRACKING RULE-MAKING DOCUMENTS

There are two steps in every regular rule-making process:
Notice of Intended Action and
Adopted and Filed

For minimum and maximum time frames, refer to "Schedule for Rule Making" printed on p. 15 herein and in the Iowa Administrative Bulletin (IAB).

| | Date |
|---|---|
| Submitted Notice of Intended Action to Administrative Rules Coordinator (ARC) | ________ |
| Notice—publication date in IAB | ________ |
| First possible review by Administrative Rules Review Committee* | ________ |
| Deadline for written comment (at least 20 days after Notice) | ________ |
| Public hearing—time and place, if any | ________ |
| First possible adoption date (35 days after publication of Notice) | ________ |
| Filing deadline for submission to ARC if adopted on first possible adoption date | ________ |
| Adopted and Filed—publication date in IAB and IAC | ________ |
| First possible effective date (35 days after publication date of the Adopted and Filed rules) | ________ |
| Expiration date of Notice of Intended Action (180 days after Notice or date of last public hearing on proposed rule, whichever is later) | ________ |

NOTE: The agency shall terminate any expired Notices of Intended Action [17A.4(1)*"b"*]

*See Agenda of Administrative Rules Review Committee meetings published at least monthly in the Iowa Administrative Bulletin.

7. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.

8. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.

9. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.

10. The petitioner requests the (designate agency) to determine whether a statute is unconstitutional on its face.

(Where the agency's experience enables it to define in advance other specific reasons for refusing to issue a declaratory order, it should include them here.)

X.9(2) A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

X.9(3) Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

**Agency No.—X.10(17A) Contents of declaratory order—effective date.** In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

**Agency No.—X.11(17A) Copies of orders.** A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

**Agency No.—X.12(17A) Effect of a declaratory order.** A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the (designate agency), the petitioner, and any intervenors (who consent to be bound) and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the (designate agency). The issuance of a declaratory order constitutes final agency action on the petition.

# CHAPTER X
# AGENCY PROCEDURE FOR RULE MAKING

**Agency No.—X.1(17A) Applicability.** Except to the extent otherwise expressly provided by statute, all rules adopted by the agency are subject to the provisions of Iowa Code chapter 17A, the Iowa administrative procedure Act, and the provisions of this chapter.

**Agency No.—X.2(17A) Advice on possible rules before notice of proposed rule adoption.** In addition to seeking information by other methods, the agency may, before publication of a Notice of Intended Action under Iowa Code section 17A.4(1)*"a,"* solicit comments from the public on a subject matter of possible rule making by the agency by causing notice to be published in the Iowa Administrative Bulletin of the subject matter and indicating where, when, and how persons may comment.

**Agency No.—X.3(17A) Public rule-making docket.**

X.3(1) *Docket maintained.* The agency shall maintain a current public rule-making docket.

X.3(2) *Anticipated rule making.* The rule-making docket shall list each anticipated rule-making proceeding. A rule-making proceeding is deemed "anticipated" from the time a draft of proposed rules is distributed for internal discussion within the agency. For each anticipated rule-making proceeding the docket shall contain a listing of the precise subject matter which may be submitted for consideration by the (commission, board, council, director) for subsequent proposal under the provisions of Iowa Code section 17A.4(1)*"a,"* the name and address of agency personnel with whom persons may communicate with respect to the matter, and an indication of the present status within the agency of that possible rule. The agency may also include in the docket other subjects upon which public comment is desired.

X.3(3) *Pending rule-making proceedings.* The rule-making docket shall list each pending rule-making proceeding. A rule-making proceeding is pending from the time it is commenced, by publication in the Iowa Administrative Bulletin of a Notice of Intended Action pursuant to Iowa Code section 17A.4(1)*"a,"* to the time it is terminated, by publication of a Notice of Termination in the Iowa Administrative Bulletin or the rule becoming effective. For each rule-making proceeding, the docket shall indicate:

*a.* The subject matter of the proposed rule;

*b.* A citation to all published notices relating to the proceeding;

*c.* Where written submissions on the proposed rule may be inspected;

*d.* The time during which written submissions may be made;

*e.* The names of persons who have made written requests for an opportunity to make oral presentations on the proposed rule, where those requests may be inspected, and where and when oral presentations may be made;

*f.* Whether a written request for the issuance of a regulatory analysis, or a concise statement of reasons, has been filed, whether such an analysis or statement or a fiscal impact statement has been issued, and where any such written request, analysis, or statement may be inspected;

*g.* The current status of the proposed rule and any agency determinations with respect thereto;

*h.* Any known timetable for agency decisions or other action in the proceeding;

*i.* The date of the rule's adoption;

*j.* The date of the rule's filing, indexing, and publication;

*k.* The date on which the rule will become effective; and

*l.* Where the rule-making record may be inspected.

**X.11(3)** Answer. An answer shall be filed within 20 days of service of the petition unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement when appropriate.

An answer shall show on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and contain as many additional defenses as the pleader may claim.

An answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

Any allegation in the petition not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

**X.11(4)** Amendment. Any notice of hearing, petition, or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

**Agency No.—X.12(17A) Service and filing of pleadings and other papers.**

**X.12(1)** *When service required.* Except where otherwise provided by law, every pleading, motion, document, or other paper filed in a contested case proceeding and every paper relating to discovery in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the state or the agency, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

**X.12(2)** *Service—how made.* Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

**X.12(3)** *Filing—when required.* After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with (specify office and address). All pleadings, motions, documents or other papers that are required to be served upon a party shall be filed simultaneously with the (agency name).

**X.12(4)** *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the (designate office), delivered to an established courier service for immediate delivery to that office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

**X.12(5)** *Proof of mailing.* Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

> I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the (agency office and address) and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).
>
> (Date) (Signature)

**Agency No.—X.13(17A) Discovery.**

**X.13(1)** Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

**X.13(2)** Any motion relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule X.13(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

**X.13(3)** Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

**Agency No.—X.14(17A) Subpoenas.**

**X.14(1)** *Issuance.*

*a.* An agency subpoena shall be issued to a party on request. Such a request must be in writing. In the absence of good cause for permitting later action, a request for a subpoena must be received at least three days before the scheduled hearing. The request shall include the name, address, and telephone number of the requesting party.

*b.* Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

**X.14(2)** *Motion to quash or modify.* The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

**Agency No.—X.15(17A) Motions.**

**X.15(1)** No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

**X.15(2)** Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by rules of the agency or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

**X.15(3)** The presiding officer may schedule oral argument on any motion.

**X.15(4)** Motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least ten days (or other time period designated by the agency) prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the agency or an order of the presiding officer.

**X.15(5)** Motions for summary judgment. Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 237 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment must be filed and served at least (45 days) prior to the scheduled hearing date, or other time period determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within (15 days), unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. The time fixed for hearing or nonoral submission shall be not less than (20 days) after the filing of the motion, unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to X.28(17A) and appeal pursuant to X.27(17A).

# AGRICULTURE AND LAND STEWARDSHIP DEPARTMENT[21]

[Created by 1986 Iowa Acts, chapter 1245]
[Prior to 7/27/88, Agriculture Department[30]]
Rules under this Department "umbrella" also include
Agricultural Development Authority[25] and Soil Conservation Division[27]


CHAPTER 1
ADMINISTRATION

1.1(159) Organization
1.2(159) Administrative division
1.3(159) Agricultural marketing division
1.4(159) Agricultural planning and policy division
1.5(159) Laboratory division
1.6(159) Regulatory division
1.7(159) Soil conservation division

CHAPTER 2
CONTESTED CASE
PRACTICE AND PROCEDURE

2.1(17A,159) Purpose—general administrative practices
2.2(17A,159) Administrative rules of practice and procedure

CHAPTER 3
PETITIONS FOR RULE MAKING

Uniform Rules

3.1(17A) Petition for rule making
3.3(17A) Inquiries
3.5(17A) Petitions for related entities

CHAPTER 4
DECLARATORY RULINGS

Uniform Rules

4.1(17A) Petition for declaratory ruling
4.3(17A) Inquiries
4.8(17A) Petitions for related entities

CHAPTER 5
AGENCY PROCEDURE
FOR RULE MAKING

Uniform Rules

5.3(17A) Public rule-making docket
5.4(17A) Notice of proposed rule making
5.5(17A) Public participation
5.6(17A) Regulatory flexibility analysis
5.11(17A) Concise statement of reasons
5.13(17A) Agency rule-making record

CHAPTER 6
PUBLIC RECORDS AND FAIR
INFORMATION PRACTICES

Uniform Rules

6.1(17A,22) Definitions
6.3(17A,22) Requests for access to records
6.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
6.9(17A,22) Disclosures without the consent of the subject
6.10(17A,22) Routine use
6.11(17A,22) Consensual disclosure of confidential records
6.12(17A,22) Release to subject
6.13(17A,22) Availability of records
6.14(17A,22) Personally identifiable information
6.15(17A,22) Other groups of records
6.16(17A,22) Data processing systems
6.17(159,252J) Release of confidential licensing information for child support recovery purposes

CHAPTER 7
CHILD SUPPORT COLLECTION
PROCEDURES

7.1(159,252J) Licensing actions
7.2(159,252J) Child support collection procedures

CHAPTERS 8 and 9
Reserved

CHAPTER 10
RURAL REVITALIZATION PROGRAM
10.1(99E) Program description
10.2(99E) Definitions
GENERAL PROVISIONS
10.3(99E) Application
10.4(99E) Deadline for submission of applications
10.5(99E) Waiver
10.6(99E) Applicant eligibility
10.7(99E) Administration
10.8(99E) Priority
10.9(99E) Ranking and evaluation criteria
10.10(99E) Process of awarding grants
10.11(99E) Noncompliance
10.12(99E) Forms
10.13(99E) Progress reports
10.14(99E) Final report
10.15(99E) Project completion date

CHAPTER 11
APPLE GRADING
11.1(73GA,HF331) Federal standards adopted
11.2(73GA,HF331) Premium utility grade apple
11.3(73GA,HF331) Inspection fees

CHAPTER 12
RENEWABLE FUELS AND COPRODUCTS
12.1(159A) Purpose
12.2(159A) Definitions
12.3(159A) General provisions
12.4(159A) Renewable fuels motor vehicle fuels decals

CHAPTERS 13 and 14
Reserved

CHAPTER 15
PILOT LAMB AND WOOL MANAGEMENT EDUCATION PROJECT
15.1(99E) Program description and administration
15.2(99E) Definitions
15.3(99E) Application
15.4(99E) Waiver
15.5(99E) Ranking and evaluation criteria
15.6(99E) Awarding of grants and noncompliance
15.7(99E) Forms
15.8(99E) Progress report
15.9(99E) Project completion date

CHAPTERS 16 to 19
Reserved

CHAPTER 20
REFERENDUM
20.1(159) Purpose
20.2(159) Definitions
20.3(159) Voter eligibility
20.4(159) Referendum methods and procedures
20.5(159) Contesting referendum results
20.6(159) Official certification

CHAPTER 21
MULTIFLORA ROSE ERADICATION PROGRAM FOR COST REIMBURSEMENT
21.1(72GA,SF511) Definitions
21.2(72GA,SF511) Form and information requirements
21.3(72GA,SF511) Mandatory cost reimbursement report

CHAPTER 22
APIARY
22.1(160) Diseases
22.2(160) Parasites
22.3(160) Requirement for the sale of bees
22.4(160) Certificate of inspection required
22.5(160) Certificate of inspection expiration
22.6(160) American Foulbrood treatment
22.7(160) Varroa mite treatment
22.8(160) Undesirable subspecies of honeybees
22.9(160) European honeybee certification
22.10(160) Prohibit movement of bees from designated states

CHAPTER 23
DAIRY TRADE PRACTICES
23.1(192A) Definitions
23.2(192A) Schools, churches and other charitable institutions not operated for profit
23.3(192A) Price differentials and discounts
23.4(192A) Gifts and promotions
23.5(192A) Consumption on the sale premises
23.6(192A) Equipment
23.7(192A) Loan guide
23.8(192A) Price filing guide
23.9(192A) Permits required
23.10(192A) Permit fees

# CHAPTER 22
# APIARY
[Prior to 7/27/88 see Agriculture Department 30—Ch 24]

**21—22.1(160) Diseases.** The diseases which the state apiarist shall inspect for are, but shall not be limited to: American Foulbrood, European Foulbrood, Nosema and Chalk Brood.

**21—22.2(160) Parasites.** The parasites for which the state apiarist shall inspect include, but shall not be limited to: the Varroa mite (Varroa jacobsoni), Tropilaelaps mite (Tropilaelaps clareae) and the honeybee tracheal mite (Acarapis woodi).

**21—22.3(160) Requirement for the sale of bees.** All honeybees offered for sale in Iowa must meet one of the following two requirements:

1. Colonies are apparently free of Varroa mites according to the detection methods listed below.
2. Colonies are under treatment with a miticide approved by EPA for control of Varroa mites in honeybee colonies and have an average of 10 or fewer Varroa mites per 300 adult bees or 500 or fewer Varroa mites per sticky board.

Detection methods to be used for the Varroa mite are the ether roll method with at least 300 adult bees per colony from 20 percent of the colonies in the apiary or the sticky board method with an EPA-approved miticide in 5 percent of the colonies in the apiary.

**21—22.4(160) Certificate of inspection required.** All honeybees transported into Iowa shall be accompanied by an approved certificate or permit issued by the state of origin or the state of Iowa. The certificate or permit shall indicate that the bees meet one of the two following requirements:

1. An average of 10 or fewer Varroa mites per 300 adult bees was detected by the ether roll test.
2. Colonies are under treatment with a miticide approved by EPA for control of Varroa mites in honeybee colonies at the time of shipment.

**21—22.5(160) Certificate of inspection expiration.** A certificate of inspection issued by the state of Iowa shall be valid for up to nine months from the date of issuance. An Iowa certificate may be revoked at any time if there is evidence of a disease or parasite infestation or Africanized bees in the certified colonies.

**21—22.6(160) American Foulbrood treatment.** If upon inspection American Foulbrood disease is detected in colonies, those colonies shall be identified and the disease abated in a timely manner that will prevent spread to neighboring colonies or apiaries as determined by the state apiarist.

The method of disease cleanup will be specified following inspection, depending on the severity of the infection and strength of the bee colony. A strong colony with a light infection of American Foulbrood may be treated with Terramycin or diseased combs removed or a combination of these methods. A severely infected, weak colony must be killed and the diseased combs destroyed by burning or melting at a temperature high enough to kill disease spores. In any case, all combs containing American Foulbrood scale shall be destroyed.

**21—22.7(160) Varroa mite treatment.** If upon inspection an average of more than 10 Varroa mites are detected in 300 bees by the ether roll method or 500 mites per colony by the sticky board method, then the apiary shall be quarantined and the owner of the apiary ordered to depopulate or treat all colonies with an EPA-approved miticide within ten days from the day the owner is notified.

If an average of 10 or fewer Varroa mites by the ether roll method or 500 or fewer mites by the sticky board method are detected, then the apiary shall be quarantined and the owner of the apiary shall be notified and given instruction on the nature of the mite infestation and the best method of treatment. Such treatment of all colonies in the apiary shall be initiated no later than October 15 of the same year.

**21—22.8(160) Undesirable subspecies of honeybees.** Each of the following undesirable subspecies of honeybees is found to be capable of inflicting damage to man or animals greater than managed or feral honeybees commonly utilized in North America and is declared a nuisance:

1. African honeybee, (Apis mellifera scutellata),
2. Cape honeybee, (Apis mellifera capensis), and
3. Any other undesirable subspecies of honeybees determined by the state apiarist to be a threat to the state.

Detection of undesirable subspecies of honeybees in the state shall initiate the quarantine of all colonies within a distance prescribed by the state apiarist of the infested apiary. All colonies within the quarantine area shall be inspected. A recommended eradication or control method shall be determined and prescribed by the state apiarist.

**21—22.9(160) European honeybee certification.** All honeybees transported into Iowa shall be accompanied by an approved certificate or permit from the state of origin indicating that the bees are European honeybees. Honeybees must be certified by one of the following methods:

1. Honeybees are located outside counties which have been determined by the state of origin to be infested with Africanized honeybees.
2. Honeybees have been tested according to the 1991 NASDA National Certification Plan and found to be European.

The certificate or permit shall state the method used to certify the bees. The certificate or permit shall be dated within 90 days prior to entry into Iowa. Africanized honeybees may not be transported into Iowa.

**21—22.10(160) Prohibit movement of bees from designated states.** A person shall not directly or indirectly transport or cause to be transported into the state of Iowa honeybees originating in the states of Florida, Georgia, North Carolina and South Carolina. As used in this rule, "honeybees" shall include, but is not limited to, the following: colonies, nucs, packages, banked queens and queen battery boxes. However, the shipping of honeybee queens and attendants in individual queen cages will be allowed when accompanied by a valid certificate of health indicating that the bees are from an apiary free of small hive beetles. This rule shall remain effective until February 18, 2000.

These rules are intended to implement Iowa Code sections 160.2, 160.9 and 160.14.

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# CRIMINAL AND JUVENILE JUSTICE PLANNING DIVISION[428]

Created by 1988 Iowa Acts, chapter 1277, sections 14 to 19, under the "umbrella" of the Department of Human Rights[421]

CHAPTER 1
FUNCTIONS
1.1(216A) Definitions
1.2(216A) Function
1.3(216A) Organization and operation
1.4(216A) Administration of the council

CHAPTER 2
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)
2.1(22) Adoption by reference
2.2(22) Custodian of records

CHAPTER 3
JUVENILE JUSTICE ADVISORY COUNCIL
3.1(216A) Definitions
3.2(216A) General purpose and guidelines
3.3(216A) Composition of the council
3.4(216A) Activities of the council
3.5(216A) State plan
3.6(216A) Juvenile justice projects
3.7(216A) Competitive grant application procedures
3.8(216A) Appeals
3.9(216A) Sole source contracts
3.10(216A) Contract agreement
3.11(216A) Contract termination
3.12(216A) Immunity of state and agencies
3.13(216A) Quarterly reports
3.14(216A) Records

CHAPTER 4
JUVENILE CRIME PREVENTION COMMUNITY GRANT FUND
4.1(232) Purpose, goals, and objectives
4.2(232) Definitions
4.3(232) Funding of grants
4.4(232) Request for proposal process
4.5(232) Eligible applicants
4.6(232) Allowable costs and cost restrictions
4.7(232) Compliance with state and federal laws
4.8(232) Contract agreement
4.9(232) Redistribution of funds
4.10(232) Contract termination
4.11(232) Immunity of state and agencies
4.12(232) Required reports
4.13(232) Subgrantee records

CHAPTER 5
JUVENILE ACCOUNTABILITY INCENTIVE BLOCK GRANT PROGRAM (JAIBG)
5.1(216A) Purpose and goals
5.2(216A) Definitions
5.3(216A) Distribution of funds
5.4(216A) Determination of funding levels
5.5(216A) Allocation of funds to units of local government
5.6(216A) Units of local government acceptance of allocations
5.7(216A) Units of local government required reports and expenditure reimbursements
5.8(216A) Allocation of funds to decategorization project governance boards
5.9(216A) Decategorization project governance boards—acceptance of allocations
5.10(216A) Decategorization project governance boards—required reports and expenditure reimbursements
5.11(216A) Competitive grant application process
5.12(216A) Appeals
5.13(216A) Redistribution of funds
5.14(216A) Allowable costs and cost restrictions

# CHAPTER 5
# JUVENILE ACCOUNTABILITY INCENTIVE BLOCK GRANT PROGRAM (JAIBG)

**428—5.1(216A) Purpose and goals.**

**5.1(1)** The purpose of the program is to provide the state and units of local government with federal Juvenile Accountability Incentive Block Grant Program funds to develop programs to promote greater accountability in the juvenile justice system.

**5.1(2)** The goals of the program are to reduce juvenile delinquency, improve the juvenile justice system, and increase accountability for juvenile offenders.

**428—5.2(216A) Definitions.** As used in this chapter:

*"Administrator"* means the administrator of the division of criminal and juvenile justice planning within the department of human rights.

*"Criminal and juvenile justice planning advisory council (CJJPAC)"* means the advisory council established in Iowa Code section 216A.132.

*"Decategorization,"* as established in Iowa Code section 232.188, means the department of human services program whereby approved counties are permitted to pool their allocations of designated state and federal child welfare and juvenile justice funding streams, establish local planning and governance structures, and design and implement service systems that are more effective in meeting local needs.

*"Decategorization project governance board"* means the board required to provide direction and governance for a decategorization project, pursuant to Iowa Code section 232.188.

*"Division"* means the division of criminal and juvenile justice planning within the department of human rights.

*"Justice Research and Statistics Association (JRSA)"* is a national nonprofit organization that provides a clearinghouse of current information on state criminal justice research, programs, and publications.

*"Juvenile"* means an individual who is 17 years of age or younger. However, individuals who are under the original or extended jurisdiction of the juvenile justice system beyond the age of 17 are eligible to receive services under the JAIBG program.

*"Juvenile Accountability Incentive Block Grant (JAIBG) purpose areas"* means the 12 program purpose areas for which JAIBG funds must be spent. The purpose areas are as follows:

Purpose area 1: Building, expanding, renovating, or operating temporary or permanent juvenile correction or detention facilities, including training of correctional personnel;

Purpose area 2: Developing and administering accountability-based sanctions for juvenile offenders;

Purpose area 3: Hiring additional juvenile judges, probation officers, and court-appointed defenders, and funding pretrial services for juveniles, to ensure the smooth and expeditious administration of the juvenile justice system;

Purpose area 4: Hiring additional prosecutors, so that more cases involving violent juvenile offenders can be prosecuted and backlogs can be reduced;

Purpose area 5: Providing funding to enable prosecutors to address drug, gang, and youth violence problems more effectively;

Purpose area 6: Providing funding for technology, equipment, and training to assist prosecutors in identifying and expediting the prosecution of violent juvenile offenders;

Purpose area 7: Providing funding to enable juvenile courts and juvenile probation offices to be more effective and efficient in holding juvenile offenders accountable and reducing recidivism;

Purpose area 8: Establishing court-based juvenile justice programs that target young firearms offenders through the establishment of juvenile gun courts for the adjudication and prosecution of juvenile firearms offenders;

Purpose area 9: Establishing drug court programs for juveniles so as to provide continuing judicial supervision over juvenile offenders with substance abuse problems and to provide the integrated administration of other sanctions and services;

Purpose area 10: Establishing and maintaining interagency information-sharing programs that enable the juvenile and criminal justice system, schools, and social services agencies to make more informed decisions regarding the early identification, control, supervision, and treatment of juveniles who repeatedly commit serious delinquent or criminal acts;

Purpose area 11: Establishing and maintaining accountability-based programs that work with juvenile offenders who are referred by law enforcement agencies, or which are designed, in cooperation with law enforcement officials, to protect students and school personnel from drug, gang, and youth violence; and

Purpose area 12: Implementing a policy of controlled substance testing for appropriate categories of juveniles within the juvenile justice system.

*"Juvenile correction facility"* means any public or private residential facility that includes permanent and temporary construction fixtures which are designed to physically restrict the movements and activities of juveniles or other individuals held in lawful custody and that is used for the placement, after adjudication and disposition, of any juvenile who has been adjudicated as having committed an offense, any nonoffender, or any other individual convicted of a criminal offense.

*"Juvenile detention facility"* means any public or private residential facility that includes permanent and temporary construction fixtures designed to physically restrict the movements and activities of juveniles or other individuals held in lawful custody and that is used for the temporary placement of any juvenile who is accused of having committed an offense, of any nonoffender, or of any other individual accused of having committed a criminal offense.

*"Juvenile justice advisory council (JJAC)"* means the federally mandated board assigned to the division of criminal and juvenile justice planning to administer federal grant funds and to improve the juvenile justice system in Iowa.

*"Juvenile Justice and Delinquency Prevention Act (JJDPA) competitive grant process"* means the procedures established in rule 428—3.7(216A).

*"Law enforcement expenditures"* means the expenditures associated with police, prosecutorial, legal, and judicial services, and corrections as reported by the local units of government to the U.S. Census Bureau, during the Census of Governments.

*"Local juvenile crime enforcement coalition (JCEC)"* means a group of individuals that develop the coordinated enforcement plan for reducing juvenile crime for units of local government. Membership shall include, unless impracticable, individuals representing the police, sheriff, prosecutor, probation services, juvenile court judge, schools, business, and religious affiliated, fraternal, nonprofit, or social service organizations involved in crime prevention.

*"Office of Juvenile Justice and Delinquency Prevention (OJJDP)"* means the federal office within the U.S. Department of Justice that administers the Juvenile Accountability Incentive Block Grant Program (JAIBG).

*"Part 1 violent crimes"* means murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault as reported to the Federal Bureau of Investigation for purposes of the Uniform Crime Reports.

*"Serious violent crimes"* means murder, aggravated sexual assault, or assault with a firearm.

*"State juvenile crime enforcement coalition (JCEC)"* means a group of individuals that develops a state plan to achieve the goals of JAIBG. The CJJPAC and the JJAC shall jointly act as the state JCEC.

*"Subgrantee"* means any local unit of government, decategorization project governance board, state department, or other nonprofit entity that receives funds from the division for JAIBG activities.

*"Unit of local government"* means a county, township, city, or political subdivision of a county, township, or city that is a unit of local government as determined by the Secretary of Commerce for general statistical purposes, and the recognized governing body of an Indian tribe that carries out substantial governmental duties and powers.

**428—5.3(216A) Distribution of funds.** The division shall distribute the JAIBG funds as follows:

1. In accordance with rule 5.5(216A), a percentage of the funds shall be distributed directly to qualified units of local government.
2. In accordance with rule 5.8(216A), a percentage of the funds may be distributed to decategorization project governance boards and any counties not participating in decategorization.
3. In accordance with rule 5.11(216A), a percentage of the funds may be distributed through the existing JJDPA competitive grant process.

**428—5.4(216A) Determination of funding levels.**

**5.4(1)** Each year funding is available, the division shall conduct a review of state and local expenditures in the JAIBG purpose areas in order to determine the primary financial burden for the administration of juvenile justice within the state of Iowa.

If, after conducting this review, the state's financial burden in the program purpose areas is greater than 50 percent of the expenditures, the division may request OJJDP's approval to distribute to units of local government a lower percentage of the available funding than the percentage initially established by Congress for units of local government. The division shall consult with units of local government or organizations representing such units prior to submitting such a request.

**5.4(2)** OJJDP shall determine the amount of funds available for units of local government. With the approval of the state JCEC, the division shall determine the amount of funds available in the categories described in 5.3"2" and "3."

**428—5.5(216A) Allocation of funds to units of local government.**

**5.5(1)** The allocations for units of local government shall be determined by formula, based on a combination of law enforcement expenditures for each unit of local government and the number of Uniform Crime Report part 1 violent crime reports by each unit of local government. Two-thirds of each unit of local government's allocation will be based on the law enforcement expenditure data and one-third will be based on the reported violent crime data, in the same ratio to the aggregate of all other units of general local government in the state.

**5.5(2)** In determining allocations, the division shall use data collected by the U.S. Census Bureau pertaining to law enforcement expenditures and the Federal Bureau of Investigation (FBI) pertaining to reported part 1 violent crime, as compiled by the JRSA, and the department of public safety (DPS) of the state of Iowa.

*a.* If data, as compiled by JRSA, indicates that units of local government have not reported law enforcement expenditures, or have reported only partial law enforcement expenditures, the division may request complete law enforcement expenditure reports directly from the affected units of local government to determine the correct allocation. If no additional information is received from local units of government within 15 calendar days after requesting such expenditure reports, the division shall use the data as presented by JRSA.

*b.* If data, as compiled by JRSA, indicates that units of local government have not reported crime data to the DPS or have reported only partial crime data, the division may request complete violent crime data directly from the affected local units of government to determine the correct allocation. If no additional data is received from local units of government within 15 calendar days after requesting such data, the division shall use the data as presented by JRSA.

5.5(3) No unit of local government shall receive an allocation that exceeds 100 percent of the law enforcement expenditures of such unit as reported to the Census Bureau.

5.5(4) In order to qualify for JAIBG funds, a unit of local government's allocation for a subgrant must be $5,000 or more. If, based on the formula, the allocation for a unit of local government is less than $5,000 during a fiscal year, the amount shall be distributed by the division to the local decategorization project governance board plan for those areas encompassing the unit of local government, as described in rule 5.8(216A).

5.5(5) If a unit of local government qualifies for a subgrant of $5,000 or more but is unable, unwilling, ineligible, or otherwise declines to participate in the JAIBG program, such funds shall be retained by the state to be reallocated among eligible units of local government in the current or the next fiscal year.

**428—5.6(216A) Units of local government acceptance of allocations.**

5.6(1) Each unit of local government that is eligible to receive JAIBG funds shall be contacted by the division and shall be provided an application which must be completed prior to receipt of the allocation. The division may require submission of the following:

*a.* Documentation of the establishment of a local JCEC.

*b.* A coordinated enforcement plan for reducing juvenile crime, which includes a budget for the proposed use of the funds within the 12 JAIBG purpose areas.

*c.* A certification that a policy of testing appropriate categories of juveniles within the juvenile justice system for use of controlled substances has been or will be implemented.

*d.* Assurances that, other than funds set aside for administration, not less than 45 percent is allocated for JAIBG purpose areas 3 through 9, and not less than 35 percent is allocated for JAIBG purpose areas 1, 2, and 10. This allocation is required unless a unit of local government certifies to the division that the interests of public safety and juvenile crime control would be better served by expending its funds in a proportion other than the above percentages. Such certification shall provide information concerning the availability of existing structures or initiatives within the intended areas of expenditure, the availability of alternative funding sources for those areas, and the reasons for the unit of local government's alternative use.

5.6(2) The units of local government shall submit the required information by the deadline established and announced by the division. The division reserves the right to extend the deadline.

5.6(3) Following its receipt and acceptance of the required application, the division shall offer the units of local government a contract authorizing the obligation of funds. These rules and all applicable state and federal laws and regulations shall become part of the contract by reference.

5.6(4) Qualifying units of local government may enter into regional coalitions by utilizing combined allocations from all participating units of local government to expend JAIBG funds using a regional juvenile crime enforcement coalition. A unit of local government, a legally authorized combination, or a decategorization project governance board shall serve as the fiscal agent(s) for receiving the award from the state and obligating and expending funds for the benefit of the combined units. The division's instructions to units of local government shall describe the process to form regional coalitions.

**5.6(5)** Qualifying units of local government may waive the right to a direct subgrant award and request that such unit's funds be awarded to and expended for its benefit by a larger or contiguous unit of local government, or decategorization project governance board.

A written waiver is required from the unit of local government which waives its right to a direct subgrant and names the requested unit of local government or decategorization project governance board to receive and expend the funds. The unit of local government or decategorization project governance board to receive the funds must agree, in writing, to accept the redirected funds and serve as the fiscal agent. The division's instructions to units of local government shall describe the process to waive a direct subcontract.

**428—5.7(216A) Units of local government required reports and expenditure reimbursements.**

**5.7(1)** Expenditure claim reports shall be required on provided forms from units of local government receiving an allocation. The division, pursuant to regular reimbursement procedures of the state of Iowa, shall reimburse expenditures to subgrantees for actual expenditures specified in the approved budget.

**5.7(2)** Progress reports on program outcomes, program status, and financial status shall be required from units of local government on provided forms.

**5.7(3)** Other reports, including audit reports prepared by independent auditors, may be required by the division and specified in its contract with the unit of local government to assist in the monitoring and evaluation of this program.

**5.7(4)** Failure to submit required reports by the due date shall result in suspension of financial payments to the units of local government by the division until such time as the reports are received. Other remedies provided by the contract may also be pursued.

**428—5.8(216A) Allocation of funds to decategorization project governance boards.**

**5.8(1)** In any year in which funds are provided for JAIBG, the division may make funds available to local decategorization project governance boards. The division shall calculate allocations to each of the decategorization project governance boards based on the number of children aged 5 to 17 years residing in the respective areas. The most recent available population data for children aged 5 to 17 years shall be used to calculate the allocations.

**5.8(2)** In any year in which the division makes JAIBG funds available to local decategorization project governance boards, the division shall make funds available to any county that is not participating in decategorization. The division shall calculate allocations to each county that is not participating in decategorization based on the number of children aged 5 to 17 years residing in the respective areas. The most recent available population data for children aged 5 to 17 years shall be used to calculate the allocations.

**428—5.9(216A) Decategorization project governance boards—acceptance of allocations.**

**5.9(1)** Each decategorization project governance board and any counties not participating in decategorization shall be contacted by the division and shall be provided an application which must be completed prior to receipt of the allocations. The division may require submission of the following:

*a.* Documentation of participation, or efforts to obtain participation, from representatives of law enforcement, county attorneys, and city governments to participate in the development of the plan.

*b.* A plan for reducing juvenile crime. The plan shall include a budget for the proposed use of the funds within the 12 JAIBG purpose areas. For decategorization project governance boards, the plan shall be developed in conjunction with the annual child welfare and delinquency plan.

**5.9(2)** The decategorization project governance boards and counties not participating in decategorization shall submit the required information by the deadline established by the division. The division reserves the right to extend the deadline.

**5.9(3)** Following its receipt and acceptance of the required information, the division shall offer the decategorization project governance boards and counties not participating in decategorization a contract authorizing the obligation of funds. These rules and all applicable state and federal laws and regulations shall become part of the contract by reference.

**5.9(4)** When a decategorization project governance board or a county not participating in decategorization is unable, unwilling, or otherwise declines to participate in the JAIBG program, such funds shall be retained by the state to be used for the development of services that have a statewide impact.

**5.9(5)** Decategorization project governance boards and counties not participating in decategorization may enter into regional coalitions by utilizing combined allocations from participating units of local government, counties not participating in decategorization, and other decategorization project governance boards to expend JAIBG funds. A unit of local government, a county, or a decategorization project governance board shall serve as the fiscal agent for receiving the award from the state and obligating and expending funds for the benefit of the combined units. The division's instructions to decategorization project governance boards and counties not participating in decategorization shall describe the process to form regional coalitions.

**428—5.10(216A) Decategorization project governance boards—required reports and expenditure reimbursements.**

**5.10(1)** Expenditure claim reports shall be required on provided forms from decategorization project governance boards receiving an allocation. The division, pursuant to regular reimbursement procedures of the state of Iowa, shall reimburse expenditures to subgrantees for actual expenditures specified in the approved budget.

**5.10(2)** Progress reports on program outcomes, program status, and financial status shall be required from decategorization project governance boards on provided forms.

**5.10(3)** Other reports, including audit reports prepared by independent auditors, may be required by the division and specified in the contract to assist in the monitoring and evaluation of this program.

**5.10(4)** Failure to submit required reports by the due date shall result in suspension of financial payments to the decategorization project governance boards by the division until such time as the reports are received. Other remedies provided by the contract may also be pursued.

**5.10(5)** Counties not participating in decategorization shall be required to submit all reports required of decategorization project governance boards, pursuant to subrules 5.10(1) to 5.10(4).

**428—5.11(216A) Competitive grant application process.** In any year in which funds are provided for this program, the division may make a percentage of funds available through the existing JJDPA competitive grant application procedures, pursuant to rule 428—3.7(216A), for projects to address one or more of the JAIBG purpose areas.

**428—5.12(216A) Appeals.**

**5.12(1)** Units of local governments, decategorization project governance boards, and counties not participating in decategorization choosing to appeal the division's allocation decisions must file a written appeal with the administrator within ten calendar days of the postmarked date of the written notification of the program's funding decisions. Appeals received after 4:30 p.m. on the tenth day will not be reviewed.

**5.12(2)** All letters of appeal must clearly state the reasons for the appeal and evidence of the reasons stated. All appeals must clearly state in what manner the division failed to follow the rules of the allocation process as governed by these administrative rules or procedures outlined in any instructions provided by the division. The letter of appeal must also describe the remedy sought.

**5.12(3)** The division shall not enter into a contract with any unit of local government for a period of ten calendar days following the written notice of the division's funding decisions for units of local governments. If an appeal is filed within the ten calendar days, the division shall not enter into a contract with any unit of local government until the administrator has reviewed and decided on all appeals received in accordance with subrules 5.12(1) and 5.12(2). The review shall be conducted as expeditiously as possible so that all funds can be distributed in a timely manner.

**5.12(4)** The division shall not enter into a contract with any decategorization project governance board or county not participating in decategorization for a period of ten calendar days following the written notice of the division's funding decisions for decategorization projects. If an appeal is filed within the ten calendar days, the division shall not enter into a contract with any decategorization project governance board or county not participating in decategorization until the administrator has reviewed and decided on all appeals received in accordance with subrules 5.12(1) and 5.12(2). The review shall be conducted as expeditiously as possible so that all funds can be distributed in a timely manner.

**5.12(5)** The appeals process for the competitive grant applicants shall be the same as the existing JJDPA competitive grant application procedures, pursuant to rule 428—3.8(216A).

**5.12(6)** The administrator's decision represents the final agency action for the purpose of judicial review under Iowa Code chapter 17A.

**428—5.13(216A) Redistribution of funds.** The division reserves the right to recapture and redistribute funds based upon projected expenditures if it appears that funds will not be expended by a subgrantee according to the conditions of the subgrantee's contract. Recaptured funds may be distributed by the administrator to subgrantees for services and activities with the purposes and goals of the program.

**428—5.14(216A) Allowable costs and cost restrictions.**

**5.14(1)** Block grant funds from this program shall be used to support only those activities and services specified and agreed to in the contract between the subgrantee and the division. The coordinated enforcement plan for reducing juvenile crime shall identify specific cost categories against which all allowable costs must be consistently charged.

**5.14(2)** Federal funds appropriated for this program shall not be expended for supplantation of federal, state, or local funds supporting existing programs or activities. Instructions for the acceptance of JAIBG allocations and competitive grant application announcements may specify other cost limitations including, but not limited to, costs related to political activities, interest costs, fines, penalties, lawsuits or legal fees, and certain fixed assets and program equipment.

These rules are intended to implement Iowa Code section 216A.133 and Public Law 105-119.

[Filed emergency 2/19/99—published 3/10/99, effective 2/19/99]

# CHAPTER 51
# ELIGIBILITY

[Prior to 7/1/83, Social Services[770] Ch 51]
[Prior to 2/11/87, Human Services[498]]

**441—51.1(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 aid to dependent children, 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.

This rule is intended to implement Iowa Code section 249.3.

**441—51.2(249) Supplementation.** Any supplemental payment made on behalf of the recipient from any source other than a nonfederal governmental entity shall be considered as income, and the payment shall be used to reduce the state supplementary assistance payment.

**441—51.3(249) Eligibility for residential care.**

**51.3(1)** *Licensed facility.* Payment for residential care shall be made only when the facility in which the applicant or recipient is residing is currently licensed by the department of inspections and appeals pursuant to laws governing health care facilities.

**51.3(2)** *Physician's statement.* Payment for residential care shall 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 shall be updated whenever a change in the recipient's physical condition warrants reevaluation, but no less than every 12 months.

**51.3(3)** *Income eligibility.* The resident shall be income eligible when the income according to 52.1(3)*"a"* is less than 31 times the per diem rate of the facility. Partners in a marriage who both enter the same room of the residential care facility in the same month shall be income eligible for the initial month when their combined income according to 52.1(3)*"a"* is less than twice the amount of allowed income for one person (31 times the per diem rate of the facility).

**51.3(4)** *Diversion of income.* Rescinded IAB 5/1/91, effective 7/1/91.

**51.3(5)** *Resources.* Rescinded IAB 5/1/91, effective 7/1/91.

This rule is intended to implement Iowa Code section 249.3.

**441—51.4(249) Dependent relatives.**

**51.4(1)** *Income.* Income of a dependent relative shall be less than $251. When the dependent's income is from earnings, an exemption of $65 shall be allowed to cover work expense.

**51.4(2)** *Resources.* The resource limitation for a recipient and a dependent child or parent shall be $2,000. The resource limitation for a recipient and a dependent spouse shall be $3,000. The resource limitation for a recipient, spouse, and dependent child or parent shall be $3,000.

**51.4(3)** *Living in the home.* A dependent relative shall be eligible until 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.

**51.4(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 shall not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

**441—51.5(249) Residence.** A recipient of state supplementary assistance shall be living in the state of Iowa.

This rule is intended to implement Iowa Code section 249.3.

**441—51.6(249) Lump sum payment.** Rescinded IAB 3/4/92, effective 5/1/92.

**441—51.7(249) Income from providing room and board.** In determining profit from furnishing room and board or providing family life home care, $251 per month shall be deducted to cover the cost, and the remaining amount treated as earned income.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

**441—51.8(249) Furnishing of social security number.** 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.

Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

**441—51.9(249) Recovery.**

**51.9(1)** *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 current or former applicant or 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 as defined in rule 441—76.10(249A).

*"Department"* means the department of human services.

**51.9(2)** *Amount subject to recovery.* The department shall 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 also shall 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.

**51.9(3)** *Notification.* All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall 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.

**51.9(4)** *Source of recovery.* Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery must come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

**51.9(5)** *Repayment.* The repayment of incorrectly expended state supplementary assistance funds shall be made to the department.

**51.9(6)** *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

This rule is 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]]

**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.

**52.1(1)** *Protective living arrangement.* The following assistance standards have been established for state supplementary assistance for persons living in a protective living arrangement:

Family life home certified under rules in 441—Chapter 111.

| | |
|---|---|
| $511.20 | care allowance |
| 71.00 | personal allowance |
| $582.20 | Total |

**52.1(2)** *Dependent relative.* The following assistance standards have been established for state supplementary assistance for dependent relatives residing in a recipient's home.

*a.* Aged or disabled client and a dependent relative ............................ $751
*b.* Aged or disabled client, eligible spouse, and a dependent relative .............. $1002
*c.* Blind client and a dependent relative ......................................... $773
*d.* Blind client, aged or disabled spouse, and a dependent relative ................ $1024
*e.* Blind client, blind spouse, and a dependent relative ........................... $1046

**52.1(3)** *Residential care.* Payment to a recipient in a residential care facility shall be made on a flat per diem rate of $17.05 or on a cost-related reimbursement system with a maximum reimbursement per diem rate of $23.83. A cost-related per diem rate shall be established for each facility choosing this method of payment according to rule 441—54.3(249).

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 shall 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 shall 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) Effective January 1, 1999, a $71 allowance 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 shall 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, shall 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, shall 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 shall 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 shall be made for the date of entry into the facility, but not the date of death or discharge.

*c.* Payment shall be made in the form of a grant to the recipient on a post payment basis.

*d.* Payment shall 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 which exceeds the 30-day annual limit. This information shall 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, Form AA-4166-0, 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 at 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.

*g.* The per diem rate established for recipients of state supplementary assistance shall not exceed the average rate established by the facility for private pay residents.

(1) Residents placed in a facility by another governmental agency are not considered private paying individuals. Payments received by the facility from such an agency shall not be included in determining the average rate for private paying residents.

(2) To compute the facilitywide average rate for private paying residents, the facility shall accumulate total monthly charges for those individuals over a six-month period and divide by the total patient days care provided to this group during the same period of time.

**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 shall 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 which were in effect in October 1972 shall be utilized.

This rule is intended to implement Iowa Code sections 234.6, 234.38, 249.2, 249.3, 249.4, and 249A.4.

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(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is $1500 or less per spouse.

(10) An amount, not in excess of $1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

*d.* *Method of attribution.* The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized and community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than $24,000, then $24,000 shall be protected for the community spouse. Also, when one-half the resources attributed to the community spouse exceeds $81,960, the amount over $81,960 shall be attributed to the institutionalized spouse. (The maximum limit shall be indexed annually by the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

*e.* *Notice and appeal rights.* The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect, or

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

*f.* *Appeals.* Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain three estimates of the cost of the annuity and these amounts shall be averaged to determine the cost of an annuity.

(5) The averaged estimates representing the cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the averaged cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the averaged cost of an annuity, there shall be no substitution for the cost of the annuity and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from three insurance companies that they will not provide estimates due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3)*"f"*(5).

**75.5(4)** Consideration of resources of married people.

*a.* One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

**75.16(2)** *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

*a. Ongoing personal needs allowance.* All clients shall retain $30 of their monthly income for a personal needs allowance with the following exception. If the client is a veteran or surviving spouse of a veteran who receives a Veterans' Administration pension subject to limitation of $90 after the month of entry pursuant to 38 U.S.C. Section 3203(f)(2), the veteran or surviving spouse of a veteran shall retain $90 from the veteran's pension for their personal needs allowance beginning the month after entry to a medical institution. The $90 allowance from a veteran's pension is in lieu of the $30 allowance from any income, not in addition thereto.

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 shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

*c. Personal needs in the month of discharge.* The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

*d. Maintenance needs of spouse and other dependents.*

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from $2,049. (This amount shall be indexed for inflation annually according to the consumer price index.)

However, if either spouse established through the appeal process that the community spouse needs income above $2,049, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

*e. Maintenance needs of children (without spouse).* When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

*f. Client's medical expenses.* A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party. This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 239.5 and 249A.4.

**441—75.17(249A) Verification of pregnancy.** For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, a signed statement from a maternal health center, family planning agency, physician's office, physician-directed qualifying provider, or advanced registered nurse practitioner who is a certified nurse midwife, as specified under the federal Social Security Act, Subsection 1902, shall serve as verification of pregnancy. Additionally, the number of fetuses shall be verified if more than one exists, and the probable date of conception shall be established when necessary to determine eligibility. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

**441—75.18(249A) Continuous eligibility for pregnant women.** A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

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(2) Accreditation by the Commission on Accreditation of Rehabilitation Agencies.

(3) Rescinded IAB 3/10/99, effective 5/1/99.

(4) Existence of a contract with or receipt of a point-in-time letter of certification from the department of elder affairs or an area agency on aging pursuant to standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

**77.30(4)** *Nursing care providers.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.30(5)** *Respite care providers.* The following providers may provide respite care:

*a.* Home health agencies which meet the conditions of participation set forth in 77.30(2) above.

*b.* Respite providers certified under the HCBS MR waiver.

*c.* Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals certified to participate in the Medicaid program.

*d.* Child foster care facilities licensed by the department according to 441—Chapters 112 to 116.

*e.* Camps accredited by the American Camping Association.

*f.* Home care agencies which meet the conditions of participation set forth in 77.30(1).

*g.* Adult day care providers which meet the conditions of participation set forth in subrule 77.30(3).

**77.30(6)** *Counseling providers.* Counseling providers shall be:

*a.* Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

*b.* Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

*c.* Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.30(7)** *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

*b.* Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

*h.* Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(27) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.31(249A) Nurse anesthetists.** Nurse anesthetists are eligible to participate in the Medicaid program if they are duly licensed by the state of Iowa and (1) they possess evidence of certification as a certified registered nurse anesthetist as set forth in board of nursing rules 655—Chapter 7 or (2) within the past 18 months, they have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists and are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing. Nurse anesthetists in other states shall be eligible to participate if they are duly licensed in that state and meet requirements (1) or (2) above. Nurse anesthetists who have been certified eligible to participate in Medicare will be considered as having met the above-stated guidelines.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.32(249A) Hospice providers.** Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.33(249A) HCBS elderly waiver service providers.** The following HCBS elderly waiver service providers shall be eligible to participate in the Medicaid program provided that they meet the standards set forth below:

**77.33(1)** *Adult day care providers.* Adult day care providers shall meet one of the following conditions:

*a.* Contract with the Veterans Administration to provide adult day health care.

*b.* Meet one of the following conditions individually or as an integral service provided by an organization:

(1) Accreditation by the Joint Commission on Accreditation of Health Care Organizations.

(2) Accreditation by the Commission on Accreditation of Rehabilitation Agencies.

(3) Rescinded IAB 3/10/99, effective 5/1/99.

(4) Existence of a contract with or receipt of a point-in-time letter of certification from the department of elder affairs or an area agency on aging pursuant to standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

77.33(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

*a.* The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

*b.* The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

*c.* There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

*d.* The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

*e.* There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) *Home health aide providers.* Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135) or which are certified as a home health agency under Medicare.

77.33(5) *Nursing care.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) *Respite care providers.* The following providers may provide respite care:

*a.* Home health agencies certified by Medicare.

*b.* Nursing facilities and hospitals certified to participate in the Medicaid program.

*c.* Camps accredited by the American Camping Association.

*d.* Respite providers certified under the HCBS MR waiver.

*e.* Home care agencies which meet the conditions of participation set forth in subrule 77.33(4).

*f.* Adult day care providers which meet the conditions set forth in subrule 77.33(1).

77.33(7) *Chore providers.* The following providers may provide chore services:

*a.* Area agencies on aging as designated in 321—4.4(231). Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide chore services may also provide chore services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers contracting with the department of public health shall be considered to have met these standards.

*d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*e.* Providers certified under the HCBS MR waiver.

**77.33(8)** *Home-delivered meals.* The following providers may provide home-delivered meals:

*a.* Area agencies on aging as designated in 321—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*d.* Restaurants licensed and inspected under Iowa Code chapter 137B.

*e.* Hospitals enrolled as Medicaid providers.

*f.* Home health aide providers meeting the standards set forth in subrule 77.33(3).

*g.* Medical equipment and supply dealers certified to participate in the Medicaid program.

*h.* Home care providers meeting the standards set forth in subrule 77.33(4).

**77.33(9)** *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

*a.* Area agencies on aging as designated in 321—4.4(231). Home and vehicle modification 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 and vehicle modification services may also provide home and vehicle modification services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Home and vehicle modification providers certified under the HCBS MR waiver.

**77.33(10)** *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

**77.33(11)** *Transportation providers.* The following providers may provide transportation:

*a.* Area agencies on aging as designated in 321—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Regional transit agencies as recognized by the Iowa department of transportation.

*d.* Rescinded IAB 3/10/99, effective 5/1/99.

*e.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

**77.33(12)** *Nutritional counseling.* The following providers may provide nutritional counseling by a licensed dietitian:

*a.* Hospitals enrolled as Medicaid providers.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*d.* Home health agencies certified by Medicare.

*e.* Licensed dietitians approved by an area agency on aging.

**77.33(13)** *Assistive devices providers.* The following providers may provide assistive devices:

*a.* Medicaid-eligible medical equipment and supply dealers.

*b.* Area agencies on aging as designated according to department of elder affairs rules 321—4.3(249D) and 321—4.4(249D).

*c.* Assistive devices providers with a contract with an area agency on aging or with a letter of approval from an area agency on aging stating the organization is qualified to provide assistive devices.

**77.33(14)** *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

**77.33(15)** *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

*b.* Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

*h.* Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(27) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.34(249A) HCBS AIDS/HIV waiver service providers.** The following HCBS AIDS/HIV waiver service providers shall be eligible to participate in the Medicaid program provided that they meet the standards set forth below:

**77.34(1)** *Counseling providers.* Counseling providers shall be:

*a.* Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

*b.* Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

*c.* Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.34(2)** *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.34(3)** *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules, 641—80.5(135), 641—80.6(135) and 641—80.7(135), or which are certified as a home health agency under Medicare.

**77.34(4)** *Nursing care providers.* Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

**77.34(5)** *Respite care providers.* Respite care providers shall be:

*a.* Home health agencies which meet the conditions of participation set forth in subrule 77.34(2).

*b.* Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals certified to participate in the Medicaid program.

*c.* Respite providers certified under the HCBS MR waiver.

*d.* Child foster care facilities licensed by the department according to 441—Chapters 112 to 116.

*e.* Camps accredited by the American Camping Association.

*f.* Home care agencies which meet the conditions of participation set forth in subrule 77.34(3).

*g.* Adult day care providers which meet the conditions of participation set forth in subrule 77.34(7).

**77.34(6)** *Home-delivered meals.* The following providers may provide home-delivered meals:

*a.* Home health aide providers meeting the standards set forth in subrule 77.34(2).

*b.* Home care providers meeting the standards set forth in subrule 77.34(3).

*c.* Hospitals enrolled as Medicaid providers.

*d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*e.* Restaurants licensed and inspected under Iowa Code chapter 137B.

*f.* Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

*g.* Area agencies on aging as designated in 321—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

*h.* Medical equipment and supply dealers certified to participate in the Medicaid program.

**77.34(7)** *Adult day care providers.* Adult day care providers shall meet one of the following conditions:

*a.* The provider shall have a contract with the veterans administration to provide adult day health care.

*b.* The provider shall meet one of the following conditions individually or as an integral service provided by an organization:

(1) Accreditation by the Joint Commission on Accreditation of Health Care Organizations.

(2) Accreditation by the Commission on Accreditation of Rehabilitation Agencies.

(3) Rescinded IAB 3/10/99, effective 5/1/99.

(4) Existence of a contract with or receipt of a point-in-time letter of certification from the department of elder affairs or an area agency on aging pursuant to standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

**77.34(8)** *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

*b.* Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

*h.* Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(27) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.35(249A) Federally qualified health centers.** Federally qualified health centers are eligible to participate in the Medicaid program when the Health Care Financing Administration has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.36(249A) Family or pediatric nurse practitioner.** Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed by the state of Iowa and they possess evidence of certification as a certified family nurse practitioner or certified pediatric nurse practitioner as set forth in board of nursing rules 655—Chapter 7. Advanced registered nurse practitioners in other states shall be eligible to participate if they are duly licensed in that state and are certified as a family nurse practitioner or a pediatric nurse practitioner. Family or pediatric nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met the above-stated guidelines.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.37(249A) HCBS MR waiver service providers.** Supported community living and supported employment providers shall be eligible to participate as approved HCBS MR service providers in the Medicaid program based on the outcome-based standards set forth below in subrules 77.37(1) and 77.37(2) evaluated according to subrules 77.37(10) to 77.37(12), the requirements of subrules 77.37(3) to 77.37(9), and the applicable subrules pertaining to the individual service. Respite providers shall meet the conditions set forth in subrules 77.37(1) and 77.37(15). Home and vehicle modification shall meet the conditions set forth in subrule 77.37(17). Personal emergency response system providers shall meet the conditions set forth in subrule 77.37(18). Nursing providers shall meet the conditions set forth in subrule 77.37(19). Home health aide providers shall meet the conditions set forth in subrule 77.37(20). Consumer-directed attendant care providers shall meet the conditions set forth in subrule 77.37(21).

77.37(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS MR providers are as follows:

*a.* The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

*b.* The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

*c.* The organization establishes and maintains fiscal accountability.

*d.* The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

*e.* The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

*f.* The organization demonstrates methods of evaluation.

(1) Past performance is reviewed.

(2) Current functioning is evaluated.

(3) Plans are made for the future based on the evaluation and review.

*g.* Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

*d.* Camps accredited by the American Camping Association.

*e.* Home care providers meeting the conditions of participation set forth in subrule 77.30(1).

*f.* Providers of services meeting the definition of foster care or day care shall also be licensed according to applicable standards of 441—Chapters 108, 109, 112, 114, 115, and 116.

*g.* Providers of services may employ or contract with individuals meeting the definition of foster family homes or family or group day care homes to provide respite services. These individuals shall be licensed according to applicable 441—Chapters 110, 112, and 113.

*h.* Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals certified to participate in the Medicaid program.

*i.* RCF/MR facilities certified by the department of inspections and appeals.

*j.* Home health agencies provided they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

**77.39(15)** *Supported employment providers.*

*a.* Providers responsible for the payroll of consumers shall have policies that include, but are not limited to:

(1) Consumer vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

(5) Both state and federal department of labor requirements.

*b.* The department shall certify only public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

**77.39(16)** *Home and vehicle modification providers.* A home and vehicle modification provider shall be an approved HCBS brain injury waiver supported community living service provider and shall meet the following standards:

*a.* The provider shall obtain a binding contract with community businesses to perform the work at the reimbursement provided by the department without additional charge. The contract shall include, at a minimum, cost, time frame for work completion, employer's liability coverage, and workers' compensation coverage.

*b.* The business shall provide physical or structural modifications to homes or vehicles according to service descriptions listed in 441—subrule 78.43(5).

*c.* The business, or the business's parent company or corporation, shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

**77.39(17)** *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

*a.* Providers shall be certified annually.

*b.* The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

**77.39(18)** *Transportation service providers.* This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

*a.* Area agencies on aging as designated in rule 321—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Regional transit agencies as recognized by the Iowa department of transportation.

*d.* Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

*e.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

**77.39(19)** *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

*a.* Medical equipment and supply dealers participating as providers in the Medicaid program.

*b.* Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

**77.39(20)** *Adult day care providers.* Adult day care providers shall meet one of the following conditions.

*a.* The provider shall have a contract with the Veterans Administration to provide adult day health care.

*b.* The provider shall meet one of the following sets of standards individually or as an integral service provided by an organization:

(1) Standards of the Joint Commission on Accreditation of Health Care Organizations.

(2) Standards set forth in rule 441—171.5(234).

(3) Standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

**77.39(21)** *Family counseling and training providers.* Family counseling and training providers shall be one of the following:

*a.* Providers which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

*b.* Providers which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

*c.* Providers which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

*d.* Providers which are qualified brain injury professionals. A qualified brain injury professional shall be 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; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health.

**77.39(22)** *Prevocational services providers.* Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

**77.39(23)** *Behavioral programming providers.* Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

*a.* Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional. Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

A qualified brain injury professional is defined in paragraph 77.39(21)*"d."*

*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 with the qualifications described in paragraph 77.39(21)*"d"* and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

77.41(4) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

*a.* Medical equipment and supply dealers participating as providers in the Medicaid program.

*b.* Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) *Transportation service providers.* The following providers may provide transportation:

*a.* Area agencies on aging as designated in 321—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Regional transit agencies as recognized by the Iowa department of transportation.

*d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

This rule is intended to implement Iowa Code section 249A.4.

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**78.13(5)** Transportation may be of any type and may be provided from any source. When transportation is by car, the maximum payment which may be made will be the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of the rate per mile payable to state employees for official travel. When public transportation is utilized, the basis of payment will be the actual charge made by the provider of transportation, not to exceed the charge that would be made by the most economical available source of public transportation. In all cases where public transportation is reasonably available to or from the source of care and the recipient's condition does not preclude its use, it must be utilized. When the recipient's condition precludes the use of public transportation, a statement to the effect shall be included in the case record.

**78.13(6)** In the case of a child too young to travel alone, or an adult or child who because of physical or mental incapacity is unable to travel alone, payment subject to the above conditions shall be made for the transportation costs of an escort. The worker is responsible for making a decision concerning the necessity of an escort and recording the basis for the decision in the case record.

**78.13(7)** When meals and lodging or other travel expenses are required in connection with transportation, payment will be subject to the same conditions as for a state employee and the maximum amount payable shall not exceed the maximum payable to a state employee for the same expenses in connection with official travel within the state of Iowa.

**78.13(8)** When the services of an escort are required subject to the conditions outlined above, payment may be made for meals and lodging, when required, on the same basis as for the recipient.

**78.13(9)** Payment will not be made in advance to a recipient or a provider of medical transportation.

**78.13(10)** Payment for transportation to receive medical care is made to the recipient with the following exceptions:

*a.* Payment may be made to the agency which provided transportation if the agency is certified by the department of transportation and requests direct payment by submitting Form 625-5297, Claim Order/Claim Voucher, within 90 days after the trip. Reimbursement for transportation shall be based on a fee schedule by mile or by trip.

*b.* In cases where the local office has established that the recipient has persistently failed to reimburse a provider of medical transportation, payment may be made directly to the provider.

*c.* In all situations where one of the department's volunteers is the provider of transportation.

**78.13(11)** Medical Transportation Claim, MA-3022-1, shall be completed by the recipient and the medical provider and submitted to the local office for each trip for which payment is requested. All trips to the same provider in a calendar month may, at the client's option, be submitted on the same form.

**78.13(12)** No claim shall be paid if presented after the lapse of three months from its accrual unless it is to correct payment on a claim originally submitted within the required time period. This time limitation is not applicable to claims with the date of service within the three-month period of retroactive Medicaid eligibility on approved applications.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.14(249A) Hearing aids.** Payment shall be approved for a hearing aid and examinations subject to the following conditions:

**78.14(1)** *Physician examination.* The recipient shall have an examination by a physician to determine that the recipient has no condition which would contraindicate the use of a hearing aid. This report shall be made on Form MA-2113-0, part 1, Report of Examination for a Hearing Aid.

**78.14(2)** *Audiological testings.* Specified audiological testing shall be performed by a physician or an audiologist as a part of making a determination that a recipient could benefit from the use of a hearing aid. The audiological testing shall be reported on Form MA-2113-0, part 2.

**78.14(3)** *Hearing aid evaluation.* A hearing aid evaluation establishing that a recipient could benefit from a hearing aid shall be made by a physician or audiologist. The hearing aid evaluation shall be reported on Form XIX-Audio-2, Hearing Aid Selection Report. When a hearing aid is recommended for a recipient the physician or audiologist recommending the hearing aid shall see the recipient at least one time within 30 days subsequent to 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 recipient's condition. When a general hearing aid recommendation is made by the physician or audiologist, a hearing aid dealer may perform the tests to determine the specific brand or model appropriate to the recipient's condition. The hearing aid selection shall be reported on Form XIX-Audio-2, Hearing Aid Selection Report.

**78.14(5)** *Travel.* When a recipient is unable to travel to the physician or audiologist because of health reasons, payment shall be made for travel to the recipient's place of residence or other suitable location. Payment to physicians shall be made as specified in 78.1(8) and payment to audiologists shall be made at the same rate at which state employees are reimbursed for travel.

**78.14(6)** *Purchase of hearing aid.* Payment shall be made for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dealer pursuant to rule 441—77.13(249A). When binaural amplification is recommended, prior approval shall be obtained from the fiscal agent before payment is made except when the binaural aid is for a child under the age of 21. Payment for binaural amplification shall be made when:

*a.* A child needs the aid for speech development, or

*b.* The aid is needed for educational or vocational purposes, or

*c.* The aid is for a blind individual.

Payment for binaural amplification shall also be considered where the recipient'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 where lack of binaural amplification poses a hazard to a recipient's safety. (Cross-reference 78.28(4)*"b"*)

**78.14(7)** *Payment for hearing aids.*

*a.* Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. Payment will be made 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.

*b.* Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

*c.* Payment for repairs shall be made for the charge to the dealer for parts and labor by the manufacturer or manufacturer's depot and for a service charge when this charge is made to the general public.

*d.* Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the recipient is under 21 years of age. Payment shall be approved when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing which would require a different hearing aid. (Cross-reference 78.28(4)*"a"*)

This rule is intended to implement Iowa Code section 249A.4.

**441—78.33(249A) Case management services.** Payment on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 24.

**78.33(1)** Payment will be approved for case management services to:

*a.* Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—22.1(225C). Persons with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

*b.* Recipients under 18 years of age with a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—22.1(225C) and with residence in a child welfare decategorization county, under the conditions stated in subrule 78.33(2).

*c.* Recipients under 18 years of age receiving HCBS MR services.

**78.33(2)** Payment for services to recipients under age 18 residing in a child welfare decategorization county shall be made when the following conditions are met:

*a.* The child welfare decategorization county has entered into an agreement with the department certifying that the state match for case management is available within funds allocated for the purpose of decategorization.

*b.* The child welfare decategorization county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation and developmental disabilities services fund administered by the department.

*c.* The child welfare decategorization county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.

**441—78.34(249A) HCBS ill and handicapped waiver services.** Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

**78.34(1)** *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

*a.* Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

*b.* Limited housecleaning: 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 dishes.

*c.* Rescinded IAB 9/30/92, effective 12/1/92.

*d.* Meal preparation planning and preparing balanced meals.

**78.34(2)** *Home health services.* Home health 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.

*a.* Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) 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.

(8) Accompaniment to medical services or transport to and from school.

*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.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

**78.34(4)** *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers 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 temporary care to a client to provide relief to the usual informal caregiver and provide all the care the usual caregiver would provide.

*a.* If the respite care is provided in the client's home, only the cost of care is reimbursed.

*b.* If the respite care is provided outside of the client's home, charges may include room and board.

*c.* A unit of service is either one 24-hour day for out-of-home respite care provided by a facility or camp, one 4- to 8-hour period of time for in-home respite care provided by a home health agency, or one hour for respite care provided by an adult day care provider, HCBS MR waiver provider, home care agency, day camp, or home health agency when the home health agency provides one to three hours of respite service.

*d.* Respite care is not to be provided to persons aged 17 or under during the hours in which the usual caregiver is employed except when the provider is a camp providing a 24-hour service.

**78.34(6)** *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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)** *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

*a.* The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

*b.* The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
(8) Colostomy care.
(9) Care of medical conditions out of control which includes 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.

*c.* A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

*d.* The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

*e.* The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

*f.* The service activities may not include parenting or child care for or on behalf of the consumer.

*g.* The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

*h.* If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

*i.* If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

*j.* The frequency or intensity of services shall be indicated in the service plan.

*k.* Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

*l.* Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

This rule is intended to implement Iowa Code section 249A.4.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

*b.* The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

*c.* A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

*d.* The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

*e.* The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

*f.* The service activities may not include parenting or child care for or on behalf of the consumer.

*g.* The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

*h.* If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

*i.* If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

*j.* The frequency or intensity of services shall be indicated in the service plan.

*k.* Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

*l.* Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.38(249A) HCBS AIDS/HIV waiver services.** Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

**78.38(1)** *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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)** *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

*a.* Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

*b.* Limited housecleaning: 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 dishes.

*c.* Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

*d.* Meal preparation: planning and preparing balanced meals.

**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 temporary care to a client to provide relief to the usual informal caregiver and provide all the care the usual caregiver would provide.

*a.* If the respite care is provided in the client's home, only the cost of care is reimbursed.

*b.* If the respite care is provided outside of the client's home, charges may include room and board.

*c.* A unit of service is either one 24-hour day for out-of-home respite care provided by a facility or camp, one 4- to 8-hour period of time for in-home respite care provided by a home health agency, or one hour for respite care provided by an adult day care provider, HCBS MR waiver provider, home care agency, day camp or home health agency when the home health agency provides one to three hours of respite service.

*d.* Rescinded IAB 3/30/94, effective 6/1/94.

*e.* When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

**78.38(6)** *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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 Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard. A maximum of 14 meals is allowed per week. A unit of service is a meal.

**78.38(7)** *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

**78.38(8)** *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

*a.* The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

*b.* The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

*c.* A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

*d.* The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

*e.* The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

*f.* The service activities may not include parenting or child care for or on behalf of the consumer.

*g.* The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

*h.* If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

*i.* If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

*j.* The frequency or intensity of services shall be indicated in the service plan.

*k.* Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

*l.* Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.39(249A) Federally qualified health centers.** Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

**78.39(1)** *Utilization review.* Utilization review shall be conducted of Medicaid recipients who access more than 24 outpatient visits in any 12-month period from physicians, family and pediatric nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the recipient lock-in program.

**78.39(2)** *Risk assessments.* Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. See description of enhanced services at subrule 78.25(3).

Federally qualified health centers which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients.

**78.39(3)** *EPSDT care coordination.* Payment for EPSDT care coordination services outlined in 78.18(6)*"b"*(2)"1" to "7" is available to Medipass eligible providers as defined in rule 441—88.41(249A) who accept responsibility for providing EPSDT care coordination services to the Medipass recipients under the age of 21 assigned to them on a monthly basis. All Medipass providers shall be required to complete Form 470-3183, Care Coordination Agreement, to reflect acceptance or denial of EPSDT care coordination responsibility. When the Medipass provider does not accept the responsibility, the Medipass patients assigned to the Medipass provider are automatically referred to the designated department of public health EPSDT care coordination agency in the recipient's geographical area. Acknowledgment of acceptance of the EPSDT care coordination responsibility shall be for a specified period of time of no less than six months. Medipass providers who identify Medipass EPSDT recipients in need of transportation assistance beyond that available according to rule 441—78.13(249A) shall be referred to the designated department of public health agency assigned to the geographical area of the recipient's residence.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.40(249A) Independently practicing family or pediatric nurse practitioners.** Payment shall be approved for services provided by independently practicing family or pediatric nurse practitioners within their scope of practice, including advanced nursing and physician-delegated functions under a protocol with a collaborating physician, with the exception of services not payable to physicians under rule 441—78.1(249A).

Family or pediatric nurse practitioners are not considered to be independently practicing when they are auxiliary personnel of a physician as defined in 78.1(13)*"b,"* or when they are employees of a hospital or clinic. An established protocol between a physician and the family or pediatric nurse practitioner shall not cause a family or pediatric nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital or clinic. The family or pediatric nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

Utilization review shall be conducted of Medicaid recipients who access more than 24 outpatient visits in any 12-month period from physicians, family and pediatric nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the recipient lock-in program.

Independently practicing family or pediatric nurse practitioners who wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Independently practicing family or pediatric nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid recipients.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.41(249A) HCBS MR waiver services.** Payment will be approved for the following services to consumers eligible for the HCBS MR waiver services as established in 441—Chapter 83 and as identified in the consumer's individual comprehensive plan (ICP). All services include the applicable and necessary instruction, supervision, assistance and support as required by the consumer in achieving the consumer's life goals. The services, amount and supports provided under the HCBS MR waiver shall be delivered in the least restrictive environment and in conformity with the consumer's individual comprehensive plan.

**78.41(7)** *Supported employment services.* Supported employment services are those services of instruction, supervision and assistance associated with attaining and maintaining paid employment.

*a.* The components of the service are instructional activities to obtain a job, initial instructional activities on the job, enclave settings as defined in paragraph *"i,"* and follow-along. The service consists of:

(1) Paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

(2) Employment-related adaptations required to assist the consumer within the employment setting.

(3) Transportation, when provided between the consumer's place of residence and the supported employment site or between sites (in situations where the consumer receives the services in more than one place). Ordinary forms of community transportation (car pools, coworkers, self or public transportation) should be attempted before the service provider provides transportation.

*b.* Individualized or dispersed placements are the preferred service model.

*c.* The majority of coworkers within the employment site which has more than two employees shall be persons without disabilities. Daily contact shall be provided in the immediate worksite with other employees or the general public who do not have disabilities.

*d.* The individual and dispersed placement services shall provide individualized and indefinite follow-along support contacts at regular intervals with the consumer to promote successful job retention. A minimum of two contacts per month is required. As appropriate, contact at regular intervals shall be made with the employer and significant others. Contacts shall be documented.

*e.* Documentation shall be maintained in the file of each supported employment consumer that this service is not available under a program funded under the Rehabilitation Act of 1973 or P. L. 94-142.

*f.* Services shall be identified in the consumer's individual comprehensive plan.

*g.* Instructional activities to obtain a job. Reimbursement is available for instructional activities provided to the consumer and supported employment development activities associated with obtaining supported employment for the consumer.

(1) A unit is one day.

(2) A maximum of five units per week are available for a maximum of 16 weeks (80 units).

*h.* Initial instructional activities on job. Reimbursement is available for instructional activities associated with initial job training needs for consumers within individual, dispersed supported employment settings.

(1) A unit is one hour.

(2) A maximum of 40 units are available per week.

*i.* Enclave settings. Reimbursement is available for activities associated with sustaining consumers within an enclave supported employment setting of two to eight persons with disabilities.

(1) A unit is one hour.

(2) A maximum of 40 units are available per week.

*j.* Follow-along. Reimbursement is available for maintenance and follow-along activities which include individualized ongoing support activities required to sustain the consumer in the supported employment setting.

(1) A unit is one calendar month.

(2) A maximum of 12 units are available per state fiscal year.

*k.* Changes in the consumer's supported employment service or support needs shall be reflected in the individual comprehensive plan. Changes in the supported employment service model will result in changes in reimbursement on a quarterly basis.

*l.* Supported employment services shall not be simultaneously reimbursed with other supported employment, work activity, or sheltered work services, or with Medicaid or HCBS MR respite, nursing or home health aide services.

*m.* Rescinded IAB 3/2/94, effective 3/1/94.

**78.41(8)** *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

*a.* The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

*b.* The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

*c.* A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

*d.* The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

*e.* The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

*f.* The service activities may not include parenting or child care for or on behalf of the consumer.

*g.* The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

*h.* If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

*i.* If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

*j.* The frequency or intensity of services shall be indicated in the service plan.

*k.* Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

*l.* Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

**441—78.42(249A) Rehabilitative treatment services.** Payment will be made for rehabilitative treatment services as described in 441—Chapter 185, Divisions II to V, when the rehabilitative treatment services have been authorized by the review organization under the provisions set forth in rule 441—185.4(234) and the services are provided by providers certified as described in rules 441—185.10(234) and 441—185.11(234).

These rules are intended to implement Iowa Code section 249A.4.

**441—78.43(249A) HCBS brain injury waiver services.** Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the participant's individual comprehensive plan (ICP). All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the ICP. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's individual comprehensive plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

**78.43(1)** *Case management services.* Individual case management services means activities provided, using an interdisciplinary process, to persons with a brain injury to ensure that the consumer has received a comprehensive evaluation and diagnosis, to give assistance to the consumer in obtaining appropriate services and living arrangements, to coordinate the delivery of services, and to provide monitoring to ensure the continued appropriate provision of services and the appropriateness of the selected living arrangement.

The service is to be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks which are a typical part of life, and fully participate as members of the community. It is essential that the case manager develop a relationship with the consumer so that the abilities, needs and desires of the consumer 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 consumers. Those who are at the ICF/MR level of care where the county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

Case management services shall consist of the following components:

*a.* Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements.

*b.* Assurance that an individual comprehensive plan (ICP) is developed which addresses the consumer's total needs for services and living arrangements.

*c.* Assistance to the consumer in obtaining the services and living arrangements identified in the ICP.

*g.* Reimbursement is available for instructional activities provided to the consumer and supported employment development activities associated with obtaining supported employment for the consumer.

(1) A unit is one day.

(2) A maximum of five units per week are available.

*h.* Reimbursement is available for instructional activities associated with initial job training needs for consumers within individual, dispersed supported employment settings.

(1) A unit is one hour.

(2) A maximum of 40 units are available per week for 16 weeks (640 units).

*i.* Reimbursement is available for activities associated with sustaining consumers within an enclave supported employment setting of two to eight persons with disabilities.

(1) A unit is one hour.

(2) A maximum of 40 units are available per week.

*j.* Reimbursement is available for maintenance and follow-along activities which include individualized ongoing support activities required to sustain the consumer in the supported employment setting.

(1) A unit is one calendar month.

(2) A maximum of 12 units are available per state fiscal year.

*k.* Changes in the consumer's supported employment service or support needs shall be reflected in the individual comprehensive plan. Changes in the supported employment service shall result in changes in reimbursement on a quarterly basis.

*l.* Supported employment services shall not be simultaneously reimbursed with other supported employment, work activity, or sheltered work services, or with Medicaid or HCBS brain injury waiver respite or personal assistance services.

*m.* Consumers residing in residential care facilities may receive supported employment services.

**78.43(5)** *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home environment and vehicle which are necessary to provide for the health, welfare and safety of the consumer, and which enable the consumer to function with greater independence in the home or vehicle.

*a.* Services shall be included in the consumer's individual comprehensive plan or service plan and shall exceed the regular Medicaid services.

*b.* These services may include the purchase, installation, or modification of:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves and ovens, grab bars and handrails.

(2) Bathtubs and toilets to accommodate wheelchair transfer, shower and bathtub seats, grab bars, special handles and hoses for shower heads, water faucet controls, wheelchair-accessible showers and sink areas, and turnaround space adaptations.

(3) Entrance ramps and rails; lifts for porches or stairs; door, hall and window widening; motion-activated, and electronic devices; air filtering, and heating and cooling adaptations.

(4) Vehicle floor or wall bracing, lifts, and driver-specific adaptations.

*c.* A unit of service is the completion of needed modifications or adaptations.

*d.* All modifications and adaptations shall be in accordance with applicable federal, state, and local building and vehicle codes.

*e.* Home and vehicle modifications shall be provided by community businesses. Services shall be performed following department approval of a contract between the supported community living provider and the community business.

*f.* Service payment shall be made to the supported community living service provider to forward to the applicable community business following completion of the approved modifications.

**78.43(6)** *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

*a.* An in-home medical communications transceiver.

*b.* A remote, portable activator.

*c.* A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

*d.* Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

*e.* The service shall be identified in the consumer's individual and comprehensive plan.

*f.* A unit is a one-time installation fee or one month of service.

*g.* Maximum units per state fiscal year are the initial installation and 12 months of service.

**78.43(7)** *Transportation.* Transportation services may be provided for consumers to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, to and from work or day programs, and to reduce social isolation. A unit of service is either per mile or per trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

**78.43(8)** *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a brain injury which provide for health and safety of the consumer which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial purchase cost.

*a.* Consumers may receive specialized medical equipment once per month until a maximum yearly usage of $6000 has been reached.

*b.* The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's individual comprehensive plan.

**78.43(9)** *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234).

**78.43(10)** *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer'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 regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

**78.43(11)** *Prevocational services.* Prevocational services are services aimed at preparing a consumer eligible for the HCBS brain injury waiver for paid or unpaid employment, but which are not job task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the individual through a state or local education agency or vocational rehabilitation services which are otherwise available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

**78.43(12)** *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer'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 ITP.

*c.* Implementation of the behavioral intervention plan.

*d.* Ongoing training and supervision to caregivers and behavioral aides.

*e.* Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

**78.43(13)** *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

*a.* The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment. Assistance while the consumer is on the job site and the cost of transportation for the consumer are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

*b.* The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes 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.

*c.* A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

*d.* The consumer, parent, or guardian shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

*e.* The consumer, parent, or guardian shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

*f.* The service activities may not include parenting or child care for or on behalf of the consumer.

*g.* The consumer and provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

*h.* If the consumer has a guardian, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met.

*i.* If the consumer has a guardian, the guardian shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

*j.* The frequency or intensity of services shall be indicated in the service plan.

*k.* Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

*l.* Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

**441—78.44(249A) Lead inspection services.** Payment shall 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.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.45(249A) Teleconsultive services.**

**78.45(1)** *Covered services.* Payment for consultations on covered services done through the electronic transfer of medical information by interactive audiovisuals is available pursuant to Medicare-funded telemedicine waiver program guidelines to those Medicaid providers participating in a federally funded telemedicine waiver program who have entered into a billing instruction and data collection agreement with the department.

**78.45(2)** *Expenses and associated costs.* Payment for telecommunication expenses and associated costs for teleconsultive services covered under subrule 78.45(1) is available to medical institutions participating in Medicaid and in a federally funded telemedicine waiver program who have entered into a billing instruction and data collection agreement with the department.

**441—78.46(249A) Physical disability waiver service.** Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

**78.46(1)** *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities listed below performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

Providers must demonstrate proficiency in delivery of the services in the consumer's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training. All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan. Consumers shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the consumer.

*a.* Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding assistance but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to, or return from, a place of employment but not assistance to the consumer while the consumer is on the job site.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting and accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of the transportation.

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| Provider category | Basis of reimbursement | Upper limit |
| --- | --- | --- |
| Family or pediatric nurse practitioner | Fee schedule | Fee schedule in effect 6/30/98 plus 2% |
| Federally qualified health centers (FQHC) | Retrospective cost-related | 1. Reasonable cost as determined by Medicare cost reimbursement principles<br>2. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" above |
| Genetic consultation clinics | Fee schedule | Reimbursement rate for clinic in effect 6/30/98 plus 2% |
| HCBS AIDS/HIV waiver service providers, including: | | |
| 1. Counseling | | |
| Individual: | Fee schedule | $9.80 per unit |
| Group: | Fee schedule | $39.20 per hour |
| 2. Home health aide | Retrospective cost-related | Maximum Medicare rate in effect on 6/30/98 plus 2% |
| 3. Homemaker | Fee schedule | $18 per hour |
| 4. Nursing care | Agency's financial and statistical cost report and Medicare percentage rate per visit | Cannot exceed $72.80 per visit |

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| 5. Respite care providers, including: | | |
| In-home: | | |
| Home health agency | Fee schedule | $104 per 4- to 8-hour unit |
| Out-of-home: | | |
| Nursing facility, or intermediate care facility for the mentally retarded | Prospective reimbursement | Limit for nursing facility level of care |
| Hospital or skilled nursing facility | Prospective reimbursement | Limit for skilled nursing facility level of care |
| Foster group care | Prospective reimbursement | P.O.S. contract rate |
| Foster family home | Fee schedule | Emergency care rate (See 156.11(2)) |
| Camps | Fee schedule | $115 per day |
| Hourly rate providers | | |
| Adult day care | Fee schedule | $12 per hour |
| HCBS MR waiver | Fee schedule See 79.1(15) | $12 per hour |
| Home care agency | Fee schedule | $12 per hour |
| Home health agency | Fee schedule | $12 per hour |
| Day camp | Fee schedule | $12 per hour |
| 6. Home-delivered meal providers | Fee schedule | $7 per meal. Maximum of 14 meals per week |
| 7. Adult day care | Fee schedule | Veterans administration contract rate or $20 per half day, $40 per full day, or $60 per extended day if no veterans administration contract. |
| 8. Consumer-directed attendant care: | | |
| Agency provider | Fee agreed upon by consumer and provider | $18 per hour<br>$104 per day |
| Individual provider | Fee agreed upon by consumer and provider | $12 per hour<br>$70 per day |

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| HCBS brain injury waiver service providers, including: | | |
| 1. Supported community livingIAC 5/6/98 | Retrospectively limited prospective rates. See 79.1(15) | $32 per hour, $72.17 per day. |
| 2. Respite care providers, including: | | |
| Nonfacility care: | Retrospectively limited prospective rates. See 79.1(15) | $12 per hour, $104 per 4- to 8-hour day |
| Facility care: | | |
| Hospital or skilled nursing facility | Prospective reimbursement | Limit for skilled nursing facility level of care |
| Nursing facility or intermediate care facility for the mentally retarded | Prospective reimbursement | Limit for nursing facility level of care |
| Foster group care | Prospective reimbursement. See 441—185.106(234) | Rehabilitative treatment and supportive services rate |
| 3. Personal emergency response system | Fee schedule | Initial one-time fee of $45. Ongoing monthly fee of $35. |
| 4. Case management | Fee schedule | $571.49 per month |
| 5. Supported employment: | | |
| a. Instructional activities to obtain a job | Fee schedule | $34.02 per day |
| b. Initial instructional activities on the job | Retrospectively limited prospective rates. See 79.1(15) | $15.46 per hour |
| c. Enclave | Retrospectively limited prospective rates. See 79.1(15) | $5.67 per hour |
| d. Follow-along | Fee schedule See 79.1(17) | $257.75 per month |
| 6. Transportation | Fee schedule | State per mile rate |
| 7. Adult day care | Fee schedule | $20 per half day, $40 per full day, or $60 per extended day |
| 8. Consumer-directed attendant care: | | |
| Agency provider | Fee agreed upon by consumer and provider | $18 per hour $104 per day |
| Individual provider | Fee agreed upon by consumer and provider | $12 per hour $70 per day |
| 9. Home and vehicle modification | Fee schedule | $500 per month, not to exceed $6,000 per year |
| 10. Specialized medical equipment | Fee schedule | $500 per month, not to exceed $6,000 per year |
| 11. Behavioral programming | Fee schedule | $9.80 per 15 minutes |

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| 12. Family counseling and training | Fee schedule | $39.20 per hour |
| 13. Prevocational services | Fee schedule. See 79.1(17) | $34.02 per day |
| HCBS elderly waiver service providers, including: | | |
| 1. Adult day care | Fee schedule | Veterans administration contract rate or $20 per half day, $40 per full day, or $60 per extended day if no veterans administration contract. |
| 2. Emergency response system | Fee schedule | Initial one-time fee $45. Ongoing monthly fee $35. |
| 3. Home health aides | Retrospective cost-related | Maximum Medicare rate in effect on 6/30/98 plus 2% |
| 4. Homemakers | Fee schedule | Maximum of $18 per hour |
| 5. Nursing care | Fee schedule as determined by Medicare | $72.80 per visit |
| 6. Respite care providers, including: | | |
| In-home: | | |
| Home health agency | Fee schedule | $104 per 4- to 8-hour unit |
| Out-of-home: Nursing facility | Prospective reimbursement | Limit for nursing facility level of care |
| Hospital or skilled nursing facility | Prospective reimbursement | Limit for skilled nursing facility level of care |
| Hourly rate providers | | |
| Adult day care | Fee schedule | $12 per hour |
| Day camp | Fee schedule | $12 per hour |
| Home care agency | Fee schedule | $12 per hour |
| Home health agency | Fee schedule | $12 per hour |
| HCBS MR waiver | Fee schedule See 79.1(15) | $12 per hour |
| 7. Chore providers | Fee schedule | $7 per half hour |
| 8. Home-delivered meal providers | Fee schedule | $7 per meal. Maximum of 14 meals per week. |
| 9. Home and vehicle modification providers | Fee schedule | $1000 lifetime maximum |
| 10. Mental health outreach providers | Fee schedule | On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year |

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| 11. Transportation providers | Fee schedule | State per mile rate for regional transit providers or rate established by area agency on aging. |
| 12. Nutritional counseling | Fee schedule | $7.50 per quarter hour |
| 13. Assistive devices | Fee schedule | $100 per unit |
| 14. Senior companion | Fee schedule | $6 per hour |
| 15. Consumer-directed attendant care: | | |
| Agency provider | Fee agreed upon by consumer and provider | $18 per hour<br>$104 per day |
| Individual provider | Fee agreed upon by consumer and provider | $12 per hour<br>$70 per day |
| HCBS ill and handicapped waiver service providers, including: | | |
| 1. Homemakers | Fee schedule | $18 per hour |
| 2. Home health aides | Retrospective cost-related | Maximum Medicare rate in effect on 6/30/98 plus 2% |
| 3. Adult day care | Fee schedule | Veterans administration contract rate or $20 per half day, $40 per full day, or $60 per extended day if no veterans administration contract. |

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| 4. Respite care providers, including: | | |
| In-home: | | |
| Home health agency | Fee schedule | $104 per 4- to 8-hour unit |
| Out-of-home: | | |
| Hospital or skilled nursing facility | Prospective reimbursement | Limit for skilled nursing facility level of care |
| Nursing facility, or intermediate care facility for the mentally retarded | Prospective reimbursement | Limit for nursing facility level of care |
| Foster group care | Prospective reimbursement. See 441—185.106(234) | Rehabilitative treatment and supportive services rate |
| Foster family home | Fee schedule | Emergency care rate (See 156.11(2)) |
| Camps | Fee schedule | $115 per day |
| Hourly rate provider | | |
| Adult day care | Fee schedule | $12 per hour |
| HCBS MR waiver | Fee schedule | $12 per hour |
| Home care agency | Fee schedule | $12 per hour |
| Home health agency | Fee schedule | $12 per hour |
| Day camp | Fee schedule | $12 per hour |
| 5. Nursing | Agency's financial and statistical cost report and Medicare percentage rate per visit | Cannot exceed $72.80 per visit |
| 6. Counseling | | |
| Individual: | Fee schedule | $9.80 per unit |
| Group: | Fee schedule | $39.20 per hour |
| 7. Consumer-directed attendant care: | | |
| Agency provider | Fee agreed upon by consumer and provider | $18 per hour<br>$104 per day |
| Individual provider | Fee agreed upon by consumer and provider | $12 per hour<br>$70 per day |

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| HCBS MR waiver service providers, including: | | |
| 1. Supported community living | Retrospectively limited prospective rates. See 79.1(15) | $32 per hour, not to exceed a total per month of $72.17 times the number of days in the month. $72.17 per day. Variations to the upper limit may be granted by the division of medical services when cost-effective and in accordance with the service plan as long as the statewide average remains at or below $72.17 per day. |
| 2. Respite care providers, including: | | |
| Nonfacility care: | Retrospectively limited prospective rates. See 79.1(15) | $12 per hour |
| Facility care: | | |
| Hospital or skilled nursing facility | Prospective reimbursement | Limit for skilled nursing facility level of care |
| Nursing facility or intermediate care facility for the mentally retarded | Prospective reimbursement | Limit for nursing facility level of care |
| Foster group care | Prospective reimbursement. See 441—185.106(234) | Rehabilitative treatment and supportive services rate |
| 3. Supported employment | | |
| a. Instructional activities to obtain a job | Fee schedule | $34.02 per day. Maximum of 80 units, 5 per week, limit 16 weeks |
| b. Initial instructional activities on the job | Retrospectively limited prospective rates. See 79.1(15) | $15.46 per hour. Maximum of 40 units per week |
| c. Enclave | Retrospectively limited prospective rates. See 79.1(15) | $5.67 per hour. Maximum of 40 units per week |
| d. Follow-along | Fee schedule See 79.1(15) | $257.75 per month. Maximum of 12 units per fiscal year or $8.45 per day for a partial month |

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| 4. Nursing | Fee schedule as determined by Medicare | Maximum Medicare rate |
| 5. Home health aides | Retrospective cost-related | Maximum Medicare rate in effect on 6/30/98 plus 2% |
| 6. Personal emergency response system | Fee schedule | Initial one-time fee of $37.40. Ongoing monthly fee of $25.50 |
| 7. Home and vehicle modifications | Contractual rate. See 79.1(15) | Maximum amount of $5,000 per consumer lifetime |
| 8. Consumer-directed attendant care: | | |
| Agency provider | Fee agreed upon by consumer and provider | $18 per hour<br>$104 per day |
| Individual provider | Fee agreed upon byconsumer and provider | $12 per hour<br>$70 per day |
| HCBS physical disability waiver service providers, including: | | |
| 1. Consumer-directed attendant care: | | |
| Agency provider | Fee agreed upon by consumer and provider | $18 per hour<br>$104 per day |
| Individual provider | Fee agreed upon by consumer and provider | $12 per hour<br>$70 per day |
| 2. Home and vehicle modification providers | Fee schedule | $500 per month, not to exceed $6000 per year |
| 3. Personal emergency response system | Fee schedule | Initial one-time fee of $45. Ongoing monthly fee of $35. |
| 4. Specialized medical equipment | Fee schedule | $500 per month, not to exceed $6000 per year |
| 5. Transportation | Fee schedule | State per mile rate for regional transit providers, or rate established by area agency on aging. Reimbursement shall be at the lowest cost service rate consistent with the consumer's needs. |

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# CHAPTER 83
# MEDICAID WAIVER SERVICES
## PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

## DIVISION I—HCBS ILL AND HANDICAPPED WAIVER SERVICES

**441—83.1(249A) Definitions.**

*"Blind individual"* means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of 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 ill and handicapped 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 person"* means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

*"Financial participation"* means client participation and medical payments from a third party including veterans' aid and attendance.

*"Intermittent homemaker service"* means homemaker service provided from one to three hours a day for not more than four days per week.

*"Intermittent respite service"* means respite service provided from one to three times a week.

*"Medical institution"* means a nursing facility or an intermediate care facility for the mentally retarded which has been approved as a Medicaid vendor.

*"Substantial gainful activity"* means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

*"Third-party payments"* means payments from an attorney, individual, institution, corporation, or public or private agency which 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.

**441—83.2(249A) Eligibility.** To be eligible for ill and handicapped 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 determined to be one of the following:

(1) Blind or disabled as determined by the receipt of social security disability benefits, or a disability determination made through the division of medical services. Disability determinations are made according to supplemental security income guidelines as per Title XVI of the Social Security Act.

(2) Aged 65 or over and residing in a county that is not served by the HCBS elderly waiver.

*b.* The person must be ineligible for medical assistance under other Medicaid programs or coverage groups with the exception of: the medically needy program, the in-home, health-related program when the person chooses the ill and handicapped waiver instead of the in-home, health-related program, the HCBS MR waiver when the person is a child under the age of 18 with mental retardation and meets the skilled nursing level of care, cases approved by the intradepartmental board for supplemental security income deeming determinations between 1982 and 1987, and children eligible for supplemental security income under Section 8010 of Public Law 101-239.

*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 and resources.

(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.

*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 the mentally retarded. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care.

Ill and handicapped waiver services will not be provided when the individual is an inpatient in a medical institution.

*e.* Rescinded IAB 12/6/95, effective 2/1/96.

*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 at paragraphs 441—75.5(2)*"b"* and 441—75.5(4)*"c"* shall be applied.

*g.* The person must have service needs that can be met by this waiver program. At a minimum a person must receive a unit of adult day care, consumer-directed attendant care, counseling, home health aid, homemaker, nursing, or respite service per quarter.

**83.2(2)** *Need for services.*

*a.* The consumer shall have a service plan approved by the department which is developed by the county social worker as identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The social worker shall establish the interdisciplinary team for the consumer and, with the team, identify the consumer's need for service based on the consumer's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form 470-0659. Form 470-0659 is completed annually, or more frequently upon request or when there are changes in the client's condition.

(2) Service plans for persons aged 20 or under shall be developed or reviewed after the child's individual education plan and EPSDT plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) Those service plans for persons aged 20 or under which include home health, homemaker, nursing, or respite services shall not be approved until a home health agency has made a request to cover the consumer's service needs through EPSDT.

*b.* The total monthly cost of the ill and handicapped waiver services shall not exceed the established aggregate monthly cost for level of care as follows:

| Skilled level of care | Nursing level of care | ICF/MR |
|---|---|---|
| $2,480 | $852 | $3,019 |

**441—83.3(249A) Application.**

**83.3(1)** *Application for HCBS ill and handicapped waiver services.* The application process as specified in rules 441—76.1(249A) to 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 ill and handicapped waiver shall be subject to the number of clients to be served as set forth in the federally approved HCBS ill and handicapped waiver. The number of clients to be served are set forth at the time of each five-year renewal of the waiver or in amendments to the waiver. When the number of applicants exceeds the number of clients specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the division of medical services.

*a.* The county office shall contact the division of medical services for all applicants for the waiver to determine if a payment slot is available.

(1) For persons not currently receiving Medicaid, the county office shall contact the division of medical services by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance.

(2) For current recipients, the county office shall contact the division of medical services by the end of the second working day after receipt of Form 470-0660, Home- and Community-Based Service Report, signed and dated by the recipient or a written request, signed and dated by the recipient.

*b.* By the end of the third day after the receipt of the completed Form PA-1107-0 or 470-0660, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is signed or date-stamped in the county office, whichever is later. Clients currently eligible for Medicaid shall be added to the waiting list on the basis of the date Form 470-0660, or a written request, is signed and dated or date-stamped in the county office, whichever is later. 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.

(2) Persons who do not fall within the available slots shall have their application rejected and their names shall be maintained on the waiting list. They shall 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.

(3) Once a payment slot is assigned, written notice shall be given to the applicant, and the payment slot shall be held for 180 days to arrange services unless the person has been determined ineligible for the program. If services are not initiated within 180 days of the written notice to the applicant, the slot reverts for use by the next applicant on the waiting list, if applicable. The applicant must reapply for a new slot.

**83.3(3)** *Approval of application.*

*a.* Applications for the HCBS ill and handicapped waiver program shall 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 which 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 completed assessment, Form SS-1644, has been submitted to the Iowa Foundation for Medical Care.

(5) The application is pending because the assessment, Form SS-1644, or the case plan 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, Form SS-1644, or case plan, the application shall be denied. The client shall have the right to appeal.

*b.* Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

*c.* A client must be given the choice between HCBS ill and handicapped waiver services and institutional care. The income maintenance or service worker shall have the client or guardian complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the client's choice of home- and community-based services or institutional care.

*d.* Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

*e.* A consumer may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the consumer is in a medical institution (hospital or nursing facility) or residential facility. Services may 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 shall be effective on the date the income and resource eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

*b.* The effective date of eligibility for the ill and handicapped waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs "*a*" and "*c*" of this subrule do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

"*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.

"*Iowa Foundation for Medical Care*" means the entity designated by the federal government to be the peer review organization for the state of Iowa.

"*Long-term care coordinating unit designated case management project for frail elderly*" means the case management system which conducts interdisciplinary team meetings to develop and update care plans for persons aged 65 and older.

"*Medical institution*" means a nursing facility which has been approved as a Medicaid vendor.

"*Project coordinator*" means the person designated by the administrative entity to oversee the long-term care coordinating unit's designated case management project for the frail elderly.

"*Third-party payments*" means payments from an individual, institution, corporation, or public or private agency which 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.

**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 at 441—paragraphs 75.5(2)"*b*" and 75.5(4)"*c*" shall be applied.

*d.* Certified as being in need of the intermediate or skilled level of care. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care.

Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

*e.* Determined to need services as described in subrule 83.22(2).

*f.* Under the case management of a member of the long-term care coordinating unit designated case management project for the frail elderly.

**83.22(2)** *Need for services.*

*a.* Applicants for elderly waiver services shall have an assessment of the need for service and the availability and appropriateness of service. The tool used to complete the assessment shall be the assessment tool designated by the long-term care coordinating unit established at Iowa Code section 231.58. The assessment shall be completed by the designated case management project for the frail elderly in the community or the local service worker. The Iowa Foundation for Medical Care shall be responsible for determining the level of care based on the completed assessment tool and supporting documentation as needed.

*b.* The total monthly cost of the elderly waiver services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs are limited as follows:

| Skilled level of care | Nursing level of care |
|---|---|
| $2,480 | $852 |

**83.22(3)** *Providers—standards.* Participants in the waiver shall be case managed by providers who meet all the following standards:

*a.* Be a member of the long-term care coordinating unit designated case management project for the frail elderly.

*b.* Have a bachelor's degree in a human services field or be currently licensed as a registered nurse. Up to two years, relevant experience may be substituted for two years of the educational requirement.

*c.* Have formal training in completion of the assessment tool.

*d.* Receive formal case management training as specified by the long-term care coordinating unit.

**441—83.23(249A) Application.**

**83.23(1)** *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

**441—83.31(249A) Conversion to the X-PERT system.** For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—83.32** to **83.40** Reserved.

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."

*"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.

*"HIV"* means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

*"Iowa Foundation for Medical Care"* means the entity designated by the federal government to be the peer review organization for the state of Iowa.

*"Medical institution"* means a nursing facility or hospital which has been approved as a Medicaid vendor.

*"Third-party payments"* means payments from an attorney, individual, institution, corporation, or public or private agency which 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.

**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. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care. AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

*c.* Be eligible for medical assistance under SSI, SSI-related, ADC, or ADC-related coverage groups; medically needy at hospital level of care; eligible under 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 which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

**83.42(2)** *Need for services.*

*a.* The county social worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form SS-1644. Form SS-1644 shall be completed annually.

*b.* The total monthly cost of the AIDS/HIV waiver services shall 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 $1650.

**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) to 441—76.6(249A) shall be followed.

**83.43(2)** *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

**83.43(3)** *Approval of application.*

*a.* Applications for the HCBS AIDS/HIV waiver program shall 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, which 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 or pended although the completed assessment, Form SS-1644, has been submitted to the Iowa Foundation for Medical Care.

(3) The application is pending because the assessment, Form SS-1644, or the case plan 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, Form SS-1644, or case plan, the application shall be denied. The client shall have the right to appeal.

"*Qualified mental retardation professional*" means a person who has at least one year of experience working directly with persons with mental retardation 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 American Occupational Therapy Association 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 American Dietetics Association.
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.

"*Staff*" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"*Third-party payments*" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which 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.

**441—83.61(249A) Eligibility.** To be eligible for HCBS MR 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 primary diagnosis of mental retardation which shall be updated based on the following time lines:

| Age | Initial application to HCBS MR waiver program | Recertification for persons with an IQ range of 54 or below, moderate range of MR or below | Recertification for persons with an IQ range of 55 or above, diagnosis of mild or unspecified range of MR |
|---|---|---|---|
| 0 through 17 years | Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or mental disability equivalent to mental retardation | After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every six years and when a significant change occurs | After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or mental disability equivalent to mental retardation every three years and when a significant change occurs |
| 18 through 21 years | • Psychological documentation substantiating diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation within three years prior to age 18, or<br>• Diagnosis of mental retardation or mental disability equivalent to mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation | Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs | Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every five years and whenever a significant change occurs |
| 22 years and above | Diagnosis made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation, if the last testing date was (1) more than five years ago for consumers with an IQ range of 55 or above or with a diagnosis of mild mental retardation, or (2) more than ten years ago for consumers with an IQ range of 54 or below or with a diagnosis of moderate MR or below | Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs | Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every five years and whenever a significant change occurs |

*b.* Be eligible for Medicaid under 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/MR. The Iowa Foundation for Medical Care shall be responsible for 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.

(1) Persons shall have their names placed on the HCBS MR waiver referral list with the division of medical services, or

(2) Currently reside in a residential care facility for the mentally retarded or foster care group home for the mentally retarded, or

(3) Currently reside in an ICF/MR or nursing facility.

*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, an adult must receive one unit of either consumer-directed attendant care, supported community living, respite, or supported employment service per calendar quarter. Children shall, at a minimum, receive one unit of either consumer-directed attendant care, respite service or supported community living service per calendar quarter under this program.

*f.* Have an individual comprehensive plan completed annually.

*g.* For supported employment services:

(1) Be at least age 18.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

*h.* Have an individual comprehensive plan or service plan approved by the department.

**83.61(2)** *Need for services.*

*a.* Consumers currently receiving Medicaid case management or services of a department-qualified mental retardation professional (QMRP) shall have the applicable coordinating staff and other interdisciplinary team members complete the Functional Assessment Tool, Form 470-3073, and identify the consumer's needs and desires as well as the availability and appropriateness of the services.

*b.* Consumers not receiving services as set forth in paragraph *"a"* who are applying for the HCBS MR waiver service shall have a department service worker or a case manager paid by the county without Medicaid funds complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination; establish an initial interdisciplinary team for HCBS MR services; and, with the initial interdisciplinary team, identify the consumer's needs and desires as well as the availability and appropriateness of services.

*c.* Persons meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

*d.* Services shall not exceed the number of maximum units established for each service.

*e.* The cost of services shall not exceed unit expense maximums. Requests shall 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 service worker, department QMRP, or Medicaid case manager shall complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-3073 or other circumstances beyond the worker's control.

*g.* At initial enrollment the service worker, department QMRP, case manager paid by the county without Medicaid funds, or Medicaid case manager shall establish an HCBS MR interdisciplinary team for each consumer and, with the team, identify the consumer's need for service based on the consumer's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Functional Assessment Tool, Form 470-3073.

(2) Service plans or individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the individual education plan (IEP) and early periodic screening, diagnosis and treatment (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) Service plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through EPSDT and receives a determination of whether EPSDT is appropriate.

(4) Service plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the division of medical services, designee or the county board of supervisors' designee. The service worker, department QMRP, or Medicaid case manager shall 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 shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the division of medical services' designee or the county board of supervisors' designee to make a decision regarding the need for supported community living beyond intermittent.

**83.61(3)** *HCBS MR program limit.* The number of persons served shall be subject to a limit based on the number of payment slots set forth in the HCBS MR waiver amendment. The department shall make a request to the Health Care Financing Administration (HCFA) to adjust the program limit annually to be effective each July 1 based upon the county management plans submitted by the state and counties. The department shall also submit a request to HCFA for changes to the program limit to be effective January 1 if requested by a county during the month of September.

*a.* The payment slots are on a county basis for adults with legal settlement in a county and are on a statewide basis for children and adults without a county of legal settlement.

*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 shall be sent to the person by the department.

**83.61(4)** *Securing a payment slot.*

*a.* The county department office shall contact the division of medical services for state cases and children or the central point of coordination administrator for the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS MR program.

(1) For persons not currently receiving Medicaid, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, or after disability determination, whichever is later.

(2) For current Medicaid recipients, the county department office shall contact the division of medical services or the county by the end of the second working day after receipt of a signed and dated Form SS-1645-0, Home- and Community-Based Service Report.

(3) A payment slot is assigned to the applicant upon confirmation of an available slot.

(4) Once assigned, written notice shall be given to the applicant, and the payment slot shall be held for the applicant for 180 days to arrange services unless the person has been determined ineligible for the program. If services are not initiated within 180 days of the date on the county department's written notice to the applicant, the slot reverts for use by the next applicant on the waiting list, if applicable. The applicant must reapply for a new slot.

*b.* On the third day after the receipt of the completed Form PA-1107-0 or SS-1645-0, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services or county according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS MR program services as documented by the date of the consumer's signature on Form SS-1645-0. 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.

(2) Persons who do not fall within the available slots shall have their application rejected, but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list. The county central point of coordination administrator for adults and the division of medical services for children and adults with state case status shall contact the county department when a slot becomes available. If services are not initiated within 180 days of the date on the county department's written notice to the consumer, the slot reverts for use by the next applicant on the waiting list, if applicable.

*"Natural supports"* means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

*"Organization"* means the entity being certified.

*"Organizational outcome"* means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

*"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 consumer that will allow the consumer 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.

*"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.

*"Staff"* means a person under the direction of the organization to perform duties and responsibilities of the organization.

*"Third-party payments"* means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

**441—83.82(249A) Eligibility.** To be eligible for brain injury waiver services a consumer 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 SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution; or be eligible for medically needy.

*c.* Be aged 1 month to 64 years.

*d.* Be a U.S. citizen and Iowa resident.

*e.* Be currently a resident of a medical institution and have been for at least 30 consecutive days at the time of initial application for the brain injury waiver.

*f.* Be determined by the Iowa Foundation for Medical Care as in need of intermediate care facility for the mentally retarded (ICF/MR), skilled nursing, or ICF level of care.

*g.* Be assessed by the Iowa Foundation for Medical Care 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.

*i.* Choose HCBS.

**83.82(2)** *Need for services.*

*a.* The consumer shall have an individual comprehensive plan approved by the department which is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed prior to services provision and annually thereafter.

The case manager shall establish the interdisciplinary team for the consumer, and with the team, identify the consumer's "need for service" based on the consumer'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 Iowa Foundation for Medical Care.

(2) Individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the child's individual education plan (IEP) and early periodic screening, diagnosis and treatment (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) ICPs for consumers aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through EPSDT and receives a determination of whether EPSDT is appropriate.

(4) ICPs for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the division of medical services designee. 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 ICP. The rationale must contain sufficient information for the division of medical services designee, or for an ICF/MR level of care consumer, the designee of the county of legal settlements board of supervisors, to make a decision regarding the need for supported community living beyond intermittent.

*b.* Rescinded IAB 7/1/98, effective 7/1/98.

*c.* Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by IFMC to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form SS-1104-0, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer'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—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall 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 shall be applied to the waiver application.

**441—83.84(249A) Client participation.** Consumers who are financially eligible under 441—subrule 75.1(7) (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 shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer'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 shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

**441—83.85(249A) Redetermination.** A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

**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 services, adult day care, and consumer-directed attendant care services, as set forth in rule 441—78.43(249A).

**441—83.87(249A) Individual comprehensive plan.** An individualized comprehensive plan (ICP) shall be prepared and utilized for each HCBS BI waiver consumer. The ICP shall be developed by an interdisciplinary team which includes the consumer and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The ICP shall be stored by the case manager for a minimum of three years. The ICP staffing shall be conducted before the current ICP expires.

**83.87(1)** *Information in plan.* The plan shall be in accordance with rule 441—24.44(225C) and shall additionally include the following information to assist in evaluating the program:

*a.* A listing of all services received by a consumer at the time of waiver program enrollment.

*b.* For supported community living consumers the plan shall include identification of:

(1) The consumers' living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

*c.* An identification and justification of any restriction of a consumer'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 consumer.

**83.87(2)** *Case plans for consumers aged 20 or under.* Case plans or individual comprehensive plans (ICPs) for consumers aged 20 or under must be developed or reviewed after the child's individual education plan (IEP) and early periodic screening, diagnosis and treatment plans (EPSDT) plan, if applicable, are developed so as not to replace or duplicate services covered by those programs.

Case plans or ICPs for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the division of medical services designee, or when a county voluntarily chooses to participate, by the county board of supervisors, designee or the division of medical services designee. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

**83.87(3)** *Annual assessment.* The Iowa Foundation for Medical Care shall assess the consumer annually and certify the consumer's need for long-term care services. The Iowa Foundation for Medical Care shall be responsible for determining the level of care based on the completed Brain Injury Waiver Functional Assessment, Form 470-3283, and supporting documentation as needed.

**83.87(4)** *Case file.* The Medicaid case manager must ensure that the consumer case file contains the consumer's ICP and, if the county is voluntarily participating, the county's final approval of service costs and the following completed forms:

*a.* Eligibility for Medicaid Waiver, Form 470-0563.

*b.* Home- and Community-Based Service Report, Form 470-0660.

*c.* Medicaid Home- and Community-Based Payment Agrèement, Form 470-0379.

*d.* Consumer Data Entry, Form 470-3280.

**441—83.88(249A) Adverse service actions.**

**83.88(1)** *Denial.* An application for services shall be denied when it is determined by the department that:

*a.* The consumer 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 consumer's individual comprehensive plan (ICP).

*a.* If a timely request for reconsideration of an initial denial determination is made, IFMC shall complete the reconsideration determination and send written notice including appeal rights to the Medicaid applicant or recipient and the applicant's or recipient's representative within ten working days after IFMC receives the request for reconsideration and a copy of the medical record.

*b.* If a copy of the medical record is not submitted with the reconsideration request, IFMC will request a copy from the facility within two working days.

*c.* The notice to parties. Written notice of the IFMC reconsidered determination will contain the following:

(1) The basis for the reconsidered determination.

(2) A detailed rationale for the reconsidered determination.

(3) A statement explaining the Medicaid payment consequences of the reconsidered determination.

(4) A statement informing the parties of their appeal rights, including the information that must be included in the request for hearing, the locations for submitting a request for an administrative hearing, and the time period for filing a request.

*d.* If the request for reconsideration is mailed or delivered to IFMC within ten days of the date of the initial determination, any medical assistance payments previously approved will not be terminated until the decision on reconsideration. If the initial decision is upheld on reconsideration, medical assistance benefits continued pursuant to this rule will be treated as an overpayment to be paid back to the department.

**441—83.110(249A) County reimbursement.** The consumer's county of legal settlement must agree to reimburse the department for all of the nonfederal share of the cost of physical disability waiver services to persons at the ICF/MR level of care with legal settlement in the county if the county chooses to participate in the physical disability waiver. The county shall enter into a Medicaid Home- and Community-Based Payment Agreement, Form 470-0379, with the department for reimbursement of the nonfederal share of the cost of services provided to HCBS physical disability waiver adults at the ICF/MR level of care.

The county shall enter into the agreement using the criteria in subrule 83.102(2).

**441—83.111(249A) Conversion to the X-PERT system.** For conversion to the X-PERT system at a time other than review, the consumer may be required to provide additional information. To obtain this information, a consumer may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

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# CHAPTER 86
# HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

## PREAMBLE

These rules define and structure the department of human services healthy and well kids in Iowa (HAWK-I) program. The purpose of this program is to provide transitional health care coverage to children ineligible for Title XIX (Medicaid) assistance or other health insurance. The program is implemented and administered in compliance with Title XXI of the federal Social Security Act. The rules establish requirements for the third-party administrator responsible for the program administration and for the participating health plans which will be delivering services to the enrollees.

**441—86.1(77GA,ch1196) Definitions.**

"*Administrative contractor*" shall mean the person or entity with whom the department contracts to administer the healthy and well kids in Iowa (HAWK-I) program.

"*Benchmark benefit package*" shall mean any of the following:

1. The standard Blue Cross Blue Shield preferred provider option service benefit plan, described in and offered under 5 U.S.C. Section 8903(1).
2. A health benefits coverage plan that is offered and generally available to state employees in this state.
3. The plan of a health maintenance organization, as defined in 42 U.S.C. Section 300e, with the largest insured commercial, nonmedical assistance enrollment of covered lives in the state.

"*Capitation rate*" shall mean the fee the department pays monthly to a participating health plan for each enrollee for the provision of covered medical services whether or not the enrollee received services during the month for which the fee is intended.

"*Contract*" shall mean the contract between the department and the person or entity selected as the third-party administrator or the contract between the department and the participating health plan for the provision of medical services to HAWK-I enrollees for whom the participating health plans assume risk.

"*Cost sharing*" shall mean the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act and 1998 Iowa Acts, chapter 1196, section 11.

"*Covered services*" shall mean all or a part of those medical and health services set forth in rule 441—86.14(77GA, ch1196).

"*Department*" shall mean the Iowa department of human services.

"*Director*" shall mean the director of the Iowa department of human services.

"*Eligible child*" shall mean an individual who meets the criteria for participation in the HAWK-I program as set forth in rule 441—86.2(77GA,ch1196).

"*Emergency medical condition*" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

"*Emergency services*" shall mean, with respect to an individual enrolled with a plan, covered inpatient and outpatient services which are furnished by a provider qualified to furnish these services and which are needed to evaluate and stabilize an emergency medical condition.

*"Enrollee"* shall mean a HAWK-I recipient who has been enrolled with a participating health plan.

*"Federal poverty level"* shall mean the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

*"Good cause"* shall mean the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee's control.
4. There was a failure to receive the third-party administrator's request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

*"HAWK-I board"* or *"board"* shall mean the entity that adopts rules, establishes policy, and directs the department regarding the HAWK-I program.

*"HAWK-I program"* or *"program"* shall mean the healthy and well kids in Iowa program implemented in this chapter to provide health care coverage to eligible children.

*"Health insurance coverage"* shall mean health insurance coverage as defined in 42 U.S.C. Section 300gg(c).

*"Institution for mental diseases"* shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

*"Nonmedical public institution"* shall mean an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined in 42 CFR Section 435.1009 as amended November 10, 1994.

*"Participating health plan"* shall mean any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

*"Physician"* shall be defined as provided in Iowa Code subsection 135.1(4).

*"Provider"* shall mean an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical care or services to an enrollee pursuant to the HAWK-I program.

*"Regions"* shall mean the six regions of the state as follows:

- Region 1: Lyon, Osceola, Dickinson, Emmet, Sioux, O'Brien, Clay, Palo Alto, Plymouth, Cherokee, Buena Vista, Woodbury, Ida, Sac, Monona, Crawford, and Carroll.
- Region 2: Kossuth, Winnebago, Worth, Mitchell, Howard, Hancock, Cerro Gordo, Floyd, Pocahontas, Humboldt, Wright, Franklin, Calhoun, Webster, Hamilton, Hardin, Greene, Boone, Story, Marshall, and Tama.
- Region 3: Winneshiek, Allamakee, Chickasaw, Fayette, Clayton, Butler, Bremer, Grundy, Black Hawk, Buchanan, Delaware, Dubuque, Jones, Jackson, Cedar, Clinton, and Scott.

*g.* Speech therapy.
*h.* Durable medical equipment.
*i.* Home health care.
*j.* Hospice services.
*k.* Prescription drugs.
*l.* Dental services (including restorative and preventative services).
*m.* Hearing services.
*n.* Vision services (including corrective lenses).

**86.14(2)** *Abortion.* Payment for abortion shall only be made under the following circumstances:

*a.* The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.

*b.* The pregnancy was the result of an act of rape or incest.

**441—86.15(77GA,ch1196) Participating health plans.**

**86.15(1)** *Licensure.* The participating health plan must be licensed by the division of insurance of the department of commerce to provide health care coverage in Iowa or be an organized delivery system licensed by the director of public health to provide health care coverage.

**86.15(2)** *Services.* The participating health plan shall provide health care coverage for the services specified in rule 441—86.14(77GA,ch1196) to all children determined eligible by the third-party administrator.

*a.* The participating health plan shall make services it provides to HAWK-I enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the plan.

*b.* Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.

*c.* If a participating plan does not provide statewide coverage, the plan shall participate in every county within the region in which the plan has contracted to provide services in which it is licensed and in which a provider network has been established. Regions are specified in rule 441—86.1(77GA, ch1196).

**86.15(3)** *Premium tax.* Premiums paid to participating health plans by the third-party administrator are exempt from premium tax.

**86.15(4)** *Provider network.* The participating health plan shall establish a network of providers. Providers contracting with the participating health plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

**86.15(5)** *Medical cards.* Medical identification cards shall be issued by the participating health plan to the enrollees for use in securing covered services.

**86.15(6)** *Marketing.*

*a.* Participating health plans may not distribute directly or through an agent or independent contractor any marketing materials.

*b.* All marketing materials require prior approval from the department.

*c.* At a minimum, participating health plans must provide the following written material:

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the HAWK-I enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(2) All plan literature and brochures shall be available in English and any other language when enrollment in the plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the plan and shall be made available to the third-party administrator for distribution.

*d.* All health plan literature and brochures shall be approved by the department.

*e.* The participating health plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

*f.* The participating health plan may make marketing presentations at the discretion of the department.

**86.15(7)** *Appeal process.* The participating health plan shall have a written procedure by which enrollees may appeal issues concerning the health care services provided through providers contracted with the plan and which:

*a.* Is approved by the department prior to use.

*b.* Acknowledges receipt of the appeal to the enrollee.

*c.* Establishes time frames which ensure that appeals be resolved within 60 days, except for appeals which involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.

*d.* Ensures the participation of persons with authority to take corrective action.

*e.* Ensures that the decision be made by a physician or clinical peer not previously involved in the case.

*f.* Ensures the confidentiality of the enrollee.

*g.* Ensures issuance of a written decision to the enrollee for each appeal which shall contain an adequate explanation of the action taken and the reason for the decision.

*h.* Maintains a log of the appeals which is made available to the department at its request.

*i.* Ensures that the participating health plan's written appeal procedures be provided to each newly covered enrollee.

*j.* Requires that the participating health plan make quarterly reports to the department summarizing appeals and resolutions.

**86.15(8)** *Appeals to the department.* Rescinded IAB 1/13/99, effective 1/1/99.

**86.15(9)** *Records and reports.* The participating health plan shall maintain records and reports as follows:

*a.* The plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the plan must maintain a medical records system that:

(1) Identifies each medical record by HAWK-I enrollee identification number.

(2) Maintains a complete medical record for each enrollee.

(3) Provides a specific medical record on demand.

(4) Meets state and federal reporting requirements applicable to the HAWK-I program.

(5) Maintains the confidentiality of medical records information and releases the information only in accordance with established policy below:

1. All medical records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical records information to physicians, other practitioners, or facilities that are providing services to enrollees under a subcontract with the plan. This provision also applies to specialty providers who are retained by the plan to provide services which are infrequently used, which provide a support system service to the operation of the plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Health Care Financing Administration (HCFA), the plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

EXCEPTION: Written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

3. Written consent is not required for the transmission of medical records information to physicians or facilities providing emergency care pursuant to paragraph 86.15(2)*"b."*

4. Written consent is required for the transmission of the medical records information of a former enrollee to any physician not connected with the plan.

5. The extent of medical records information to be released in each instance shall be based upon a test of medical necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical records maintained by subcontractors shall meet the requirements of this rule.

*b.* Each plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

(1) A list of providers of medical services under the plan.

(2) Information regarding the plan's appeals process.

(3) A plan for a health improvement program.

(4) Periodic financial, utilization and statistical reports as required by the department.

(5) Encounter data on a monthly basis as required by the department.

(6) Time-specific reports which define activity for child health care, appeals, and other designated activities which may, at the department's discretion, vary among plans, depending on the services covered and other differences.

(7) Other information as directed by the department.

**86.15(10)** *Systems.* The participating health plan shall maintain data files that are compatible with the department's and third-party administrator's systems.

**86.15(11)** *Payment to the participating health plan.*

*a.* In consideration for all services rendered by a plan, the plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to the enrollees.

*b.* The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

*c.* The capitation rate does not include any amounts for the recoupment of losses suffered by the plan for risks assumed under the current or any previous contract. The plan accepts the rate as payment in full for the contracted services. Any savings realized by the plan due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the plan.

*d.* If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical expenses, it is the right and responsibility of the plan to investigate these third-party resources and attempt to obtain payment. The plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

**86.15(12)** *Quality assurance.* The plan shall have in effect an internal quality assurance system.

These rules are intended to implement 1998 Iowa Acts, chapter 1196.

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(1) The parent is in academic or vocational training. Child care provided while the parent participates in postsecondary education or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending dates falling within two calendar months but shall only count as one month. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the 24-month limit. PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

(2) The parent is employed 28 or more hours per week, or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment of a single parent or the coinciding hours of employment of both parents in a two-parent home, and for actual travel time between home, child care facility, and place of employment.

(3) The parent needs child day care as part of a protective service plan to prevent or alleviate child abuse or neglect.

(4) The person who normally cares for the child is absent from the home due to hospitalization, physical or mental illness, or death. Care under this paragraph is limited to a maximum of one month, unless extenuating circumstances are justified and approved after case review by the regional administrator.

(5) The parent is looking for employment. Child care for job search shall be limited to only those hours the parent is actually looking for employment including travel time. A job search plan shall be approved by the department and limited to a maximum of 30 working days in a 12-month period. Child care in two-parent families may be provided only during the coinciding hours of both parents' looking for employment, or during one parent's employment and one parent's looking for employment. Documentation of job search contacts shall be furnished to the department. The department may enter into a nonfinancial coordination agreement for information exchange concerning job search documentation.

**170.2(3)** *Priority for service.* Funds available for child day care services shall first be used to continue services to families currently receiving child day care services and to families with protective child care needs. As funds are determined available, families shall be served on a statewide basis from a regionwide waiting list based on the following schedule in descending order of prioritization. Applications for child day care services shall be taken only for the priority groupings for which funds have been determined available.

*a.* Families with an income at or below 100 percent of the federal poverty level whose members are employed at least 28 hours per week, and parents with a family income at or below 100 percent of the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

*b.* Rescinded IAB 7/6/94, effective 7/1/94.

*c.* Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

*d.* Families with an income of more than 100 percent but not more than 140 percent of the federal poverty guidelines whose members are employed at least 28 hours per week.

*e.* Families with an income at or below 175 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special needs child as a member of the family.

*f.* Rescinded IAB 7/6/94, effective 7/1/94.

*g.* Rescinded IAB 9/9/98, effective 11/1/98.

**170.2(4)** *Prioritization within child care subsidized programs.*

*a.* When families are determined to be eligible for Transitional Child Care, this shall be the program in which they are enrolled, as long as funds are available.

*b.* Any recipient of the family investment program who is in academic or vocational training and on a PROMISE JOBS waiting list for expense allowances including child care shall not be eligible for subsidy for the hours in academic or vocational training under the child care assistance program.

**441—170.3(234) Goals.** Appropriate goals for child day care services are those described in 441—subrule 130.7(1), paragraphs *"a," "c,"* and *"d."*

**441—170.4(234) Elements of service provision.**

**170.4(1)** *Case plan.* The case plan shall be developed by the department service worker and contain information described in 441—subrule 130.7(2), when the child meets the need for service under 170.2(3)*"d."*

**170.4(2)** *Fees.* Fees are assessed and collected in accordance with rule 441—130.4(234).

**170.4(3)** *Method of provision.* The department shall issue the Child Care Certificate, Form 470-2959, to the client to select a child day care provider. Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)*"b"*(3), as long as the conditions in paragraph 170.4(7)*"d"* are met. When the child meets the need for service under 170.2(2)*"b"*(3), parents shall be allowed to exercise their choice of licensed or registered child care provider except when the department service worker determines it is not in the best interest of the child.

The department shall make payment for child day care provided to eligible families when the Child Care Certificate, Form 470-2959, has been completed and signed by the parent, the provider, and the department worker, and when the provider meets the applicable requirements set forth below.

*a.* Licensed child care center. A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form SS-1203-3.

*b.* Registered group day care home. A group day care home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form SS-1209-3.

*c.* Registered family day care home. A family day care home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form SS-1202-3.

*d.* Relative care. An adult relative who provides care in the relative's own home solely for a related child may receive payment for child day care services when selected by the parent.

*e.* In-home care. The adult caretaker selected by the parent to provide care in the child's own home shall be sent the pamphlet Comm. 95, Minimum Health and Safety Requirements for Nonregistered Family Day Care Home Providers, and Form 470-2890, Payment Application for Nonregistered Providers. Form 470-2890 shall be signed by the provider and returned to the department within 15 days before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include: minimum health and safety requirements, limits on the number of children for whom care may be provided, unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order, and conditions that warrant nonpayment.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of individual and family support services. The provider shall submit the original request, the response received, and any additional information desired to the bureau chief. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director's designee within 15 calendar days of the decision. The director or director's designee shall issue the final department decision within 15 calendar days of receipt of the request.

**441—170.5(234) Adverse service actions.** Services may be denied, terminated, or reduced according to rule 441—130.5(234). The department may refuse to enter into or may revoke the Child Care Certificate, Form 470-2959, if a hazard to the safety and well-being of a child is found by the department of human services, and the provider cannot or refuses to correct the hazards; or if the provider has submitted claims for payment for which the provider is not entitled.

**441—170.6(234) Appeals.** Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

**441—170.7(234) Transitional child care.** Rescinded IAB 7/6/94, effective 7/1/94.

**441—170.8(234) Allocation of funds.** The department shall allocate funds for child day care services to the regional offices of the department to ensure that the current need and projected growth in services to families currently receiving child day care services and to families with protective child care needs are met. The funds for nonprotective child day care services shall be allocated based on the expenditures of the regional office proportional to the total state expenditures for nonprotective child day care services. The funds for protective child day care services shall be allocated based on historical data, with 60 percent of the total allocation to the regional office based on the number of founded child abuse cases in the region proportional to the total number of founded child abuse cases in the state, and 40 percent of the total allocation to the regional office based on the number of child abuse reports in the region proportional to the total number of child abuse reports in the state. The department may redistribute any unobligated funds from the original allocation to the regional offices based on the number of children living in the region whose family income is at or below 100 percent of the federal poverty guidelines.

The regional office of the department shall manage the child day care funds allocated to the region and shall distribute the allocation among the counties within the region based on, but not limited to, the factors used to allocate funds to the regional offices. The regional office may redistribute any unobligated funds from the original allocation to the county offices to ensure that the current need and projected growth in services to families currently receiving child day care services and to families with protective child care needs are met.

These rules are intended to implement Iowa Code section 234.6(6)*"a."*

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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]]

**441—177.1(249) In-home health related care.** In-home health related care is a program of nursing care in an individual's own home to provide personal services to an individual because such individual's state of physical or mental health prevents independent self-care.

**441—177.2(249) Own home.** Own home means an individual's house, apartment, or other living arrangement intended for single or family residential use.

**441—177.3(249) Service criteria.** The client shall require health care services that would require the supervision of a professional registered nurse working under the certification of a physician.

**177.3(1)** Skilled services may include but not be limited to:

*a.* Gavage feedings of individuals unable to eat solid foods.

*b.* Intravenous therapy administered only by a registered nurse.

*c.* Intramuscular injections required more than once or twice a week, excluding diabetes.

*d.* Catheterizations, continuing care of indwelling catheters with supervision of irrigations and changing of Foley catheter when required.

*e.* Inhalation therapy.

*f.* Care of decubiti and other ulcerated areas, noting and reporting to physician.

*g.* Rehabilitation services including, but not limited to: bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activity of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation and behavior modification.

*h.* Tracheotomy care.

*i.* Colostomy care until the individual is capable of maintaining the colostomy personally.

*j.* Care of medical conditions out of control which includes brittle diabetes and terminal conditions.

*k.* Postsurgical nursing care, but only for short time periods, and primarily for individuals with complications following surgery, or with the need for frequent dressing changes.

*l.* Monitoring medications needed for close supervision of medications because of fluctuating physical or psychological conditions, i.e., hypertensives, digitalis preparations, narcotics.

*m.* Diets which are therapeutic and require evaluation at frequent intervals.

*n.* Vital signs which is the recording and reporting of change in vital signs to the attending physician.

**177.3(2)** Personal care services may include but not be limited to:

*a.* Supervision on a 24-hour basis for physical or emotional needs.

*b.* Helping client with bath, shampoo, oral hygiene.

*c.* Helping client with toileting.

*d.* Helping client in and out of bed and with ambulation.

*e.* Helping client to reestablish activities of daily living.

*f.* Assisting with oral medications ordinarily self-administered and ordered by the 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.

**441—177.4(249) Eligibility.**

**177.4(1)** *Eligible individual.*

*a.* The individual shall be eligible for supplemental security income in every respect except for income.

*b.* The physician's certification shall include a statement of the specific health care services and that the services can be provided in the individual's own home. The certification shall be given on Form SS-1719-0, Assessment of Functional Capacity of Client and Recommendation for Services, or on a similar plan of care form presently used by public health agencies.

*c.* The individual shall live in the individual's own home.

*d.* The client shall require and be receiving qualified health care services. Qualified health care services are health care services supervised by a registered nurse and approved by a physician.

**177.4(2)** *Relationship to other programs.* In-home health related care shall be provided only when other existing programs cannot meet the client's need.

**177.4(3)** *Maximum costs.* The maximum cost of service shall be $458.20. The provider shall accept the payment made and shall make no additional charges to the recipient or others.

**177.4(4)** *Service plan.* A complete service plan shall be prepared which includes the services needed, the plan for providing these services, and the health care plan defined in rule 177.6(249).

**177.4(5)** *Certification procedure.* The approval by the area office of the department of human services of the case plan shall constitute certification and approval for payment.

**177.4(6)** *Temporary absence from home.* The client will remain eligible and payment will be made for services for a period not to exceed 15 days in any calendar month when the client is absent from the home for a temporary period. 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.

**177.4(7)** *Income for adults.* The gross income of the individual and spouse, living in the home, shall be limited to $458.20 per month if one needs care or $916.40 if both need care, with the following disregards:

*a.* The amount of the basic supplemental security income standard for an individual or a couple, as applicable.

*b.* When income is earned, $65.00 plus one-half of any remaining income.

*c.* The amount of the supplemental security income 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.

*d.* The amount of the established medical needs of the ineligible spouse which are not otherwise met.

*e.* The amount of the established medical needs of the applicant or recipient which are not otherwise met and would not be met if the individual were eligible for the medical assistance program.

*f.* Rescinded, effective 7/1/84.

**177.4(8)** *Income for children.*

*a.* 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 supplemental security income 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 supplemental security income 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 supplemental security income 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, $65.00 plus one-half of the remainder of the earned income.

*b.* The income of the child shall be limited to $458.20 per month with the following disregards:

(1) The amount of the basic supplemental security income standard for an individual.

(2) The amount of the established medical needs of the child which 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.

*c.* Rescinded, effective 7/1/84.

**177.4(9)** *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 shall 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 shall 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 power of attorney are considered to be legally designated.

*c.* Payment for the program shall be approved effective as of the date of application or the date all eligibility requirements are met and qualified health care services are provided, whichever is later, notwithstanding 42 U.S.C. 1382(c)(7).

**177.4(10)** *Application.* Application for in-home health related care shall be made on Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance. An eligibility determination shall 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 supplemental security income benefits.

*b.* The application is pending because the department has not received information, which 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 SS-1511-0, Provider Agreement, has not been completed and completion is beyond control of the client. When a Provider Agreement cannot be completed due to client's failure to locate a provider, applications shall not be held pending beyond 60 days from the date of application.

This rule is intended to implement Iowa Code section 249.3(2)*"a."*

**441—177.5(249) Providers of health care services.**

**177.5(1)** *Age.* The provider shall be at least 18 years of age.

**177.5(2)** *Physician's report.* The provider shall obtain a physician's report at the time service is initiated and annually thereafter. The report shall be on Form SS-1718-0, Provider Health Assessment Form.

**177.5(3)** *Qualifications.* The provider shall be qualified by training and experience to carry out the health care plan as specified in rule 177.4(4).

**177.5(4)** *Relative.* The provider may be related to the client, so long as the provider is not a member of the family as defined in rule 441—130.1(234).

**177.5(5)** Rescinded IAB 8/9/89, effective 10/1/89.

This rule is intended to implement Iowa Code section 249.3(2)*"a."*

**441—177.6(249) Health care plan.** The nurse shall complete the health care plan with the physician's approval. The health care plan shall include the specific types of services required, the method of providing those services, and the expected duration of services.

**177.6(1)** *Transfer from medical facility.* When the client is being transferred from a medical hospital or long-term care facility, the service worker shall obtain a transfer document describing the client's current care plan, to be provided to the nurse supervising the in-home care plan.

**177.6(2)** *Medical records.*

*a.* Medical records shall include, whenever appropriate, transfer forms, physician's certification and orders, interdisciplinary case plan, interdisciplinary progress notes, drug administration records, treatment records, and incident reports. The nurse shall be responsible for ensuring that record requirements are met.

*b.* Medical records shall be located in the nurse's case file, with a copy of the interdisciplinary plan of care and physician's plan of service in the service worker's file, and all other records available to the service worker. Upon termination of the in-home care plan, the records shall be maintained in the county office of the department of human services, or in the office of the public health nurse and available to the service worker, for five years or until completion of an audit.

*c.* The client or legal representative shall have the right to view the client's medical records.

**177.6(3)** *Review.* The continuing need for in-home health care services shall be reviewed:

*a.* At a minimum of every 60 days by the physician, including a written recertification of continuing appropriateness of the plan;

*b.* At a minimum of every three months by the service worker, including a review of the total care plan; and

*c.* At a minimum of every 60 days by the nurse who shall review the nursing plan.

More frequent reviews may be required by the physician, the service worker, or the nurse.

**177.6(4)** *Annual physical.* The client shall obtain a physical examination report annually and shall be under the regular supervision of a physician.

This rule is intended to implement Iowa Code section 249.3(2)*"a"*(2).

**441—177.7(249) Client participation.**

**177.7(1)** All income remaining after the disregards in 177.4(7) and 177.4(8) shall be considered income available for services and shall be used for service costs before payment for in-home health care begins.

**177.7(2)** First month. 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.

This rule is intended to implement Iowa Code section 249.3(2)*"a"*(2).

**441—177.8(249) Determination of reasonable charges.** Payment will be made only for reasonable charges for in-home health care services as determined by the service worker. Reasonableness shall be determined by:

**177.8(1)** *Community standards.* The prevailing community standards for cost of care for similar services.

**177.8(2)** *Services at no charge.* The availability of service providers at no cost to the department.

This rule is intended to implement Iowa Code section 249.3(2)*"a"*(2).

**441—177.9(249) Written agreements.**

**177.9(1)** *Independent contractor.* The provider shall be an independent contractor and shall in no sense be an agent, employee or servant of the state of Iowa, the Iowa department of human services, any of its employees, or of its clients.

**177.9(2)** *Liability coverage.* All professional health care providers shall have adequate liability coverage consistent with their responsibilities, as the department of human services assumes no responsibility for, or liability for, individuals providing care.

**177.9(3)** *Provider agreement.* The client and the provider shall enter into an agreement, using Form SS-1511-0, Provider Agreement, 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 of human services as stated in the Provider Agreement by using Form 470-1999, Amendment to Provider Agreement.

This rule is intended to implement Iowa Code section 249.3(2)*"a"*(2).

**441—177.10(249) Emergency services.** Written instructions for dealing with emergency situations shall be completed by the nurse and maintained in the client's home and in the county department of human services office. The instructions shall include:

**177.10(1)** *Persons to notify.* The name and telephone number of the client's physician, the nurse, responsible family members or other significant persons, and the service worker.

**177.10(2)** *Hospital.* Information as to which hospital to utilize.

**177.10(3)** *Ambulance.* Information as to which ambulance service or other emergency transportation to utilize.

This rule is intended to implement Iowa Code section 249.3(2)*"a"*(2).

**441—177.11(249) Termination.** Termination of in-home health related care shall occur under the following conditions.

**177.11(1)** *Request.* Upon the request of the client or legal representative. When termination of the program would result in an individual being unable to protect the individual's own interests, arrangements for guardianship, commitment, or protective placements shall be provided.

**177.11(2)** *Care unnecessary.* When the client becomes sufficiently self-sustaining to remain in the client's own home with services that can be provided by existing community agencies as determined by the service worker.

**177.11(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 service worker.

**177.11(4)** *Excessive costs.* When the cost of care exceeds the maximum established in 177.4(3).

**177.11(5)** *Other services utilized.* When the service worker determines that other services can be utilized to better meet the client's needs.

**177.11(6)** *Terms of provider agreement not met.* When it has been determined by the service worker 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.

This rule is intended to implement Iowa Code section 249.3(2)*"a"*(2).

441—177.12 Rescinded IAB 8/9/89, effective 10/1/89.

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# NATURAL RESOURCE COMMISSION[571]

[Prior to 12/31/86, see Conservation Commission [290], renamed Natural Resource Commission[571] under the "umbrella" of Department of Natural Resources by 1986 Iowa Acts, chapter 1245]


TITLE I
*GENERAL*

CHAPTER 1
OPERATION OF
NATURAL RESOURCE COMMISSION

1.1(17A,455A) Scope
1.2(17A,455A) Time of meetings
1.3(17A,455A) Place of meetings
1.4(17A,455A) Notification of meetings
1.5(17A,455A) Attendance and participation by the public
1.6(17A,455A) Quorum and voting requirements
1.7(17A,455A) Conduct of meeting
1.8(17A,455A) Minutes, transcripts, and recordings of meetings
1.9(17A,455A) Officers and duties
1.10(17A,455A) Election and succession of officers
1.11(68B) Sales of goods and services

CHAPTER 2
PUBLIC RECORDS AND
FAIR INFORMATION PRACTICES

2.1(22) Adoption by reference

CHAPTER 3
SUBMISSION OF INFORMATION AND
COMPLAINTS—INVESTIGATIONS

3.1(17A) Adoption by reference

CHAPTER 4
AGENCY PROCEDURE
FOR RULE MAKING

4.1(17A) Adoption by reference

CHAPTER 5
PETITIONS FOR RULE MAKING

5.1(17A) Adoption by reference

CHAPTER 6
DECLARATORY RULINGS

6.1(17A) Adoption by reference

CHAPTER 7
RULES OF PRACTICE
IN CONTESTED CASES

7.1(17A) Adoption by reference

CHAPTER 8
CONTRACTS FOR PUBLIC
IMPROVEMENTS AND PROFESSIONAL
SERVICES

8.1(17A) Adoption by reference

CHAPTER 9
STATE MIGRATORY WATERFOWL,
TROUT AND HABITAT STAMP DESIGN
CONTESTS

9.1(483A,484A) Design contests
9.2(483A,484A) Selection of promoter
9.3(483A,484A) Stamp design-related proceeds
9.4(483A,484A) Design
9.5(483A,484A) Commissioned design
9.6(483A,484A) Financial records
9.7(483A,484A) Title to property

CHAPTER 10
FORFEITED PROPERTY

10.1(809) Purpose
10.2(809) Definitions
10.3(809) Jurisdiction
10.4(809) Supervisor approval
10.5(809) Disposition of general property
10.6(809) Disposition of weapons
10.7(809) Property destroyed
10.8(809) Disposition of furs

CHAPTERS 11 and 12
Reserved

CHAPTER 13
PERMITS AND EASEMENTS FOR
CONSTRUCTION AND OTHER
ACTIVITIES ON PUBLIC LANDS
AND WATERS

13.1(461A) Purpose
13.2(461A) Definitions
13.3(461A) Permit required
13.4(461A) Application
13.5(461A) Permit issued or denied
13.6(461A) Additional information or analysis required
13.7(461A) Leases and easements
13.8(461A) Appeals
13.9(461A) Unauthorized construction

TITLE II
*LICENSES, PERMITS AND CONCESSION CONTRACTS*

CHAPTER 14
CONCESSIONS

14.1(461A) Definitions
14.2(461A) Advertising or notice procedure
14.3(461A) Bidding process
14.4(461A) Selection of a concessionaire
14.5(461A) Concession contract—general
14.6(461A) Dispute resolution
14.7(461A) Suspension or termination for cause
14.8(461A) Severability

CHAPTER 15
GENERAL LICENSE REGULATIONS

15.1(483A) Hunter safety and ethics education program
15.2(483A) License depositaries
15.3(483A) Lost or destroyed license blanks
15.4(483A) Fishing license exemption for patients of substance abuse facilities
15.5(481A) Authorization to use a crossbow for deer and turkey hunting during the bow season by handicapped individuals
15.6(481A) Multiple offenders—revocation and suspension of hunting, fishing, and trapping privileges from those persons who are determined to be multiple offenders
15.7(483A) Free hunting and fishing license for low-income persons 65 years of age and older, or low-income persons who are permanently disabled
15.8(483A) Free lifetime fishing license for persons who have severe physical or mental disabilities
15.9(483A) Volunteer hunter education instructors
15.10(483A,321G,462A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors and boating safety instructors
15.11(483A) Transportation tags for military personnel on leave from active duty
15.12(483A) Refunds or changes for special deer and turkey permits and general licenses

CHAPTER 16
PUBLIC, COMMERCIAL, PRIVATE DOCKS AND DOCK MANAGEMENT AREAS

16.1(461A) Definitions
16.2(461A) When dock permit required
16.3(461A) General permit for certain private docks on lakes
16.4(461A) General permit for certain private docks on rivers and river impoundments
16.5(461A) Standard requirements for all docks
16.6(461A) Applications for individual dock permits
16.7(461A) Criteria for individual private dock permits
16.8(461A) Additional requirements for public and commercial docks
16.9(461A) Establishment of dock management areas
16.10(461A) Fees for commercial docks, docks in dock management areas and private docks requiring an individual permit
16.11(461A) Liability

CHAPTER 17
BARGE FLEETING REGULATIONS

17.1(461A) Applicability
17.2(461A) Fleeting operations
17.3(461A) General
17.4(461A) Riparian rights
17.5(461A) Prohibited areas
17.6(461A) Restricted areas
17.7(461A) Applicant—content of application
17.8(461A) Notices and opportunity for hearing
17.9(461A) Application review
17.10(461A) Lease
17.11(461A) Nonuse
17.12(461A) Reports of use
17.13(461A) Renewals
17.14(461A) Permit and lease revocation
17.15(461A) Severability

CHAPTER 18
RENTAL FEE SCHEDULE FOR STATE-OWNED PROPERTY, RIVERBED, LAKEBED, AND WATERFRONT LANDS
18.1(461A) General
18.2(461A) Table 1—Areas designated for industrial or commercial use by the natural resource commission
18.3(461A) Table 2—Areas designated for noncommercial use or use by nonprofit organizations
18.4(461A) Other fees

CHAPTER 19
SAND AND GRAVEL PERMITS
19.1(461A) Purpose
19.2(461A) Definitions
19.3(461A) Permit applications
19.4(461A) Permit conditions and operating procedures

CHAPTER 20
MANUFACTURER'S CERTIFICATE OF ORIGIN
20.1(462A) Definitions
20.2(462A) Applicability
20.3(462A) Certificate of origin—content
20.4(462A) Procedure—manufacturer
20.5(462A) Procedure—dealer
20.6(462A) Procedure—purchaser
20.7(462A) Procedure—county recorder
20.8(462A) Vessel titling

TITLE III
*ASSISTANCE PROGRAMS*

CHAPTER 21
AGRICULTURAL LEASE PROGRAM
21.1(456A) Purpose
21.2(456A) Definitions
21.3(456A) Agricultural lease policy
21.4(456A) Lease procedures

CHAPTER 22
WILDLIFE HABITAT ON PRIVATE LANDS PROMOTION PROGRAM
22.1(456A,483A) Purpose
22.2(456A,483A) Authority
22.3(456A,483A) Project scope
22.4(456A,483A) Availability of funds
22.5(483A) Winter habitat areas
22.6(456A,483A) Shelterbelts
22.7(456A,483A) Cost reimbursement

CHAPTER 23
WILDLIFE HABITAT PROMOTION WITH LOCAL ENTITIES PROGRAM
23.1(483A) Purpose and definitions
23.2(483A) Availability of funds
23.3(483A) Eligibility
23.4(483A) Project limitations
23.5(483A) Eligibility for cost-sharing assistance
23.6(483A) Application for assistance
23.7(483A) Project review and selection
23.8(483A) Commission review
23.9(483A) Grant amendments
23.10(483A) Timely commencement of projects
23.11(483A) Project period
23.12(483A) Payments
23.13(483A) Record keeping and retention
23.14(483A) Penalties

CHAPTER 24
Reserved

CHAPTER 25
CERTIFICATION OF LAND AS NATIVE PRAIRIE OR WILDLIFE HABITAT
25.1(427) Purpose
25.2(427) Definitions
25.3(427) Restrictions
25.4(427) Maintenance
25.5(427) Certification
25.6(427) Application for exemption
25.7(427) Decertification

CHAPTER 26
RELOCATION ASSISTANCE

26.1(316) Definitions
26.2(316) Actual reasonable moving costs and related expenses
26.3(316) Replacement housing payments for homeowners
26.4(316) Replacement housing payments for tenants and certain others
26.5(316) Notice of relocation assistance advisory service
26.6(316) Preconstruction project certificate
26.7(316) Record of payment determinations and claims for benefits paid
26.8(316) Last resort housing

CHAPTER 27
LANDS AND WATERS CONSERVATION FUND PROGRAM

27.1(456A) Purpose
27.2(456A) Apportionment distribution
27.3(456A) Eligibility requirements
27.4(456A) Assistance ceiling
27.5(456A) Grant application submission
27.6(456A) Project review and selection
27.7(456A) Public participation
27.8(456A) Commission review
27.9(456A) Federal review
27.10(456A) Grant amendments
27.11(456A) Timely commencement of projects
27.12(456A) Project period
27.13(456A) Reimbursements
27.14(456A) Ineligible items
27.15(456A) Record keeping and retention

CHAPTER 28
SNOWMOBILE AND ALL-TERRAIN VEHICLE REGISTRATION REVENUE COST-SHARE PROGRAM

28.1(321G) Purpose and intent
28.2(321G) Distribution of funds
28.3(321G) Application procedures
28.4(321G) Review and selection committees
28.5(321G) Project selection criteria
28.6(321G) Director's review of approved projects
28.7(321G) Eligibility of projects
28.8(321G) Land acquisition procedures
28.9(321G) Use of funded items
28.10(321G) Disposal of equipment, facilities or property
28.11(321G) Record keeping
28.12(321G) Sponsors bonded
28.13(321G) Items eligible for funding
28.14(321G) Items specific to the snowmobile cost-share program
28.15(321G) Prepayment for certain anticipated costs
28.16(321G) Expense documentation, balance payment or reimbursement

CHAPTER 29
LOCAL RECREATION INFRASTRUCTURE GRANTS PROGRAM

29.1(8,77GA,ch1219) Purpose
29.2(8,77GA,ch1219) Definitions
29.3(8,77GA,ch1219) Eligibility requirements
29.4(8,77GA,ch1219) Assistance ceiling and cost share
29.5(8,77GA,ch1219) Minimum grant amount
29.6(8,77GA,ch1219) Grant application submission
29.7(8,77GA,ch1219) Project review and selection
29.8(8,77GA,ch1219) Rating system not used
29.9(8,77GA,ch1219) Applications not approved for funding
29.10(8,77GA,ch1219) Commission review
29.11(8,77GA,ch1219) Grant amendments
29.12(8,77GA,ch1219) Timely commencement of projects
29.13(8,77GA,ch1219) Payments
29.14(8,77GA,ch1219) Record keeping and retention
29.15(8,77GA,ch1219) Eligible projects
29.16(8,77GA,ch1219) Project life and recovery of funds
29.17(8,77GA,ch1219) Unlawful use of funds
29.18(8,77GA,ch1219) Remedy
29.19(8,77GA,ch1219) Ineligibility

CHAPTER 30
WATER RECREATION ACCESS COST-SHARE PROGRAM

30.1(452A) Purpose
30.2(452A) Availability of funds
30.3(452A) Eligibility of development projects
30.4(452A) Eligibility of acquisition projects
30.5(452A) Projects not eligible
30.6(452A) Waiver of retroactivity
30.7(452A) Establishing project priorities
30.8(452A) Application procedures
30.9(452A) Cost-sharing rates
30.10(452A) Joint sponsorship
30.11(452A) Control of project site
30.12(452A) Project agreements
30.13(452A) Reimbursement procedures
30.14(77GA,SF2381) Implementation of pilot program for state and local cooperative lake rehabilitation

CHAPTER 31
PUBLIC-OWNED LAKES ELIGIBILITY PROCESS

31.1(456A) Purpose
31.2(456A) Definitions
31.3(456A) Eligibility review and selection procedures
31.4(456A) Commission review

CHAPTER 32
PRIVATE OPEN SPACE LANDS

32.1(9H) Applicability
32.2(9H) Definition

CHAPTER 33
RESOURCE ENHANCEMENT AND PROTECTION PROGRAM: COUNTY, CITY AND PRIVATE OPEN SPACES GRANT PROGRAMS

PART 1
GENERAL PROVISIONS

33.1(455A) Purpose
33.2(455A) Resource enhancement policy
33.3(455A) Definitions
33.4(455A) Restrictions
33.5(455A) Grant applications, general procedures
33.6(455A) Appraisals
33.7(455A) Groundwater hazard statements
33.8(455A) Rating systems not used
33.9(455A) Applications not selected for grants
33.10(455A) Similar development projects
33.11(455A) Commission review and approval
33.12(455A) Timely commencement and completion of projects
33.13(455A) Waivers of retroactivity
33.14(455A) Project amendments
33.15(455A) Payments
33.16(455A) Record keeping and retention
33.17(455A) Penalties
33.18 Reserved
33.19(455A) Property tax reimbursement
33.20(455A) Public hearing
33.21(455A) Conflict of interest
33.22 to 33.29 Reserved

PART 2
COUNTY GRANTS

33.30(455A) County conservation account
33.31 to 33.39 Reserved

PART 3
CITY GRANTS

33.40(455A) Competitive grants to cities
33.41 to 33.49 Reserved

PART 4
PRIVATE GRANTS

33.50(455A) Private cost-sharing program

CHAPTER 34
COMMUNITY FORESTRY CHALLENGE GRANT PROGRAM (CFCGP)

34.1(461A) Purpose
34.2(461A) Definitions
34.3(461A) Availability of funds
34.4(461A) Eligibility of forestry development projects
34.5(461A) Eligibility of demonstration projects
34.6(461A) Projects not eligible
34.7(461A) Eligible applicants
34.8(461A) Establishing project priorities
34.9(461A) Application procedures
34.10(461A) Requirements for funding
34.11(461A) Project agreements
34.12(461A) Reimbursement procedures

CHAPTER 35
Reserved

TITLE IV
*RECREATIONAL VESSEL AND VEHICLE REGISTRATION AND SAFETY*

CHAPTER 36
GREEN VALLEY LAKE
SPECIAL WATER ACTIVITY RULES

36.1(462A) General
36.2(462A) Inboard boats
36.3(462A) Racing craft
36.4(462A) Wake
36.5(462A) Speed
36.6(462A) Hours
36.7(462A) Ski zone
36.8(462A) Traffic pattern
36.9(462A) Designated activities in ski zone
36.10(462A) Designated areas
36.11(462A) Traffic
36.12(462A) Lifesaving device
36.13(462A) Speed
36.14(462A) Distance from shore
36.15(462A) Horsepower limitation

CHAPTER 37
BOATING SAFETY EQUIPMENT

37.1(462A) Fire extinguishers
37.2(462A) Flame arrester required
37.3 to 37.5 Reserved
37.6(462A) Lights on vessels
37.7(462A) Lighting requirements for sailing vessels
37.8(462A) Sailing vessels with auxiliary power
37.9 to 37.12 Reserved
37.13(462A) Buoyant safety equipment

CHAPTER 38
BOAT REGISTRATION
AND NUMBERING

38.1(462A) Emblem placed
38.2 to 38.5 Reserved
38.6(462A) Procedure for application of boat registration number—content
38.7 to 38.9 Reserved
38.10(462A) Information on certificate
38.11(462A) Registration applied for card
38.12 to 38.14 Reserved
38.15(462A) Numbering pattern to be used
38.16 to 38.18 Reserved
38.19(462A) Display of number on vessel, as to size, block type and contrasting color
38.20 to 38.24 Reserved
38.25(462A) Number designating passenger capacity
38.26 to 38.29 Reserved
38.30(462A) Boats for hire

CHAPTER 39
BOATING PASSENGER CAPACITY

39.1(462A) U.S. Coast Guard capacity rating
39.2(462A) Vessels assigned a capacity rating by the manufacturer
39.3(462A) Vessels not containing capacity rating information
39.4(462A) Incorrect registration

CHAPTER 40
BOATING SPEED AND
DISTANCE ZONING

40.1(462A) Restricted areas
40.2(462A) Uniform buoy system
40.3(462A) Commission approval
40.4(462A) Right for aggrieved party to appeal
40.5(462A) Rathbun Lake, Appanoose County—zoned areas
40.6(462A) Red Rock Lake, Marion County—zoned areas
40.7(462A) Coralville Lake, Johnson County—zoned areas
40.8(462A) Saylorville Lake, Polk County—zoned areas
40.9(462A) Lake Odessa in Louisa County
40.10(462A) Mississippi River lock and dam safety zone
40.11(462A) Joyce Slough Area
40.12(462A) Swan Slough, Camanche, Iowa
40.13(462A) Massey Slough
40.14(462A) Black Hawk County waters
40.15(462A) Mitchell County waters
40.16(462A) Maquoketa River
40.17(462A) Zoning of off-channel waters of the Wapsipinicon River in Pinicon Ridge Park in Linn County

**15.6(7)** *Dates of suspension or revocation.* The suspension or revocation shall be effective upon failure of the person to request a hearing within 30 days of the notice described in 15.6(6) or upon issuance of an order affirming the department's intent to suspend or revoke the license after the hearing. The person shall immediately surrender all licenses and shall not apply for or obtain new licenses for the full term of the suspension or revocation.

**15.6(8)** *Magistrate authority.* This chapter does not limit the magistrate authority as described in Iowa Code section 483A.21.

**571—15.7(483A) Free hunting and fishing license for low-income persons 65 years of age and older, or low-income persons who are permanently disabled.**

**15.7(1)** *Purpose.* Pursuant to Iowa Code subsection 483A.24(14), the department of natural resources will issue a free annual combination hunting and fishing license to low-income persons who meet the age status or permanently disabled status as defined.

**15.7(2)** *Definitions.*

*"Age status"* means a person who has achieved the sixty-fifth birthday.

*"Low-income person"* means a person who is a recipient of a program administered by the state department of human services for persons who meet low-income guidelines.

*"Permanently disabled"* means a person who meets the definition in Iowa Code section 483A.4.

**15.7(3)** *Procedure.* Each person shall apply to the department of natural resources for a license as follows:

*a.* Application shall be made on a form provided by the department and shall include the name, address, height, weight, color of eyes and hair, date of birth, and gender of the applicant. In addition, applicants shall include a copy of an official document such as a birth certificate if claiming age status, or a copy of an award letter from the Social Security Administration or private pension plan if claiming permanent disabled status. The applicant shall indicate on the application which low-income assistance program the applicant is receiving. The application shall include an authorization allowing the department of human services to verify that the applicant is a recipient of the low-income assistance program checked on the application.

*b.* The free annual combination license will be issued by the department upon receipt of a properly completed application. The license will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain a free license.

*c.* A person whose income falls below the federal poverty guidelines, but is not a recipient of a state assistance program, may apply for this license by providing the following:

(1) A statement listing income from all sources (i.e., social security, retirement income, wages, dividends and interest, cash gifts, rents and royalties, and other cash income).

(2) A copy of any available document that verifies income (i.e., income tax return, bank statement, social security statement, or other document the applicant considers supportive of income status).

(3) A signed statement by the applicant that the applicant's annual cash income does not exceed the federal poverty limit for the current year.

Federal poverty guidelines are published in February of each year and will be the income standard for applicants from that time until the new limits are available in the subsequent year. The income limit will be shown on the application and will be available upon request from the department.

This rule is intended to implement Iowa Code section 483A.24(17).

**571—15.8(483A) Free lifetime fishing license for persons who have severe physical or mental disabilities.**

**15.8(1)** *Purpose.* Pursuant to Iowa Code subsection 483A.24(9), the department of natural resources will issue a free lifetime fishing license to Iowa residents 16 or more years of age who have severe mental or physical disabilities who meet the definitions of "Severe mental disability" and "Severe physical disability" in 15.8(2).

**15.8(2)** *Definitions.* For the purposes of this rule, the following definitions apply:

*"Severe mental disability"* means a person who has severe, chronic conditions in all of the following areas which:

1. Are attributable to a mental impairment or combination of mental and physical impairments;
2. Are likely to continue indefinitely;
3. Result in substantial functional limitations 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, or economic self-sufficiency; and
4. Reflect the person's need for a combination and sequence of services which are of lifelong or an extended duration and are individually planned and coordinated.

*"Severe physical disability"* means a disability that limits or impairs the person's ability to walk under any of the following circumstances:

1. The person cannot walk 200 feet without stopping to rest.
2. The person cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device.
3. The person is restricted by lung disease to such an extent that the person's forced expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest.
4. The person must use portable oxygen.
5. The person has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class 3 or Class 4 according to standards set by the American Heart Association.

• Class 3—Persons with cardiac disease resulting in marked limitation of physical activity. The person is comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or angina pain.

• Class 4—Persons with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

6. The person is severely limited in the person's ability to walk due to an arthritic, neurological, or orthopedic condition.

**15.8(3)** *Procedure.* Each person shall apply to the department of natural resources for a license as follows:

*a.* Application shall be made on a form provided by the department and shall include the name, address, home telephone number, height, weight, eye and hair color, date of birth, and gender of the applicant.

*b.* The application shall be signed and certified by the applicant's attending physician and, based upon the criteria listed in this rule, declare that the applicant has a severe mental or physical disability.

**571—15.9(483A) Volunteer hunter education instructors.**

**15.9(1)** *Purpose.* Pursuant to Iowa Code subsection 483A.27(4), the department will certify volunteer instructors to teach the hunter education and ethics course as provided in this chapter.

**15.9(2)** *Definitions.* For the purposes of this rule:

*"Certified instructor"* means a person who has met all criteria in this rule.

*"Course"* means the department's hunter education and ethics course.

*"Department"* means the Department of Natural Resources, Wallace State Office Building, Des Moines, Iowa 50319-0034.

*"Instructor applicant"* means a person who has applied to become a certified volunteer hunter education instructor.

**15.9(3)** *Minimum qualifications.* The following conditions must be satisfied before any person can become a certified instructor. Failure to meet these conditions will result in the denial of the application. The instructor applicant will be notified of the denial by the recreational safety coordinator. An instructor applicant shall:

*a.* Submit an application as provided by the department to the local conservation officer or recreational safety officer.

*b.* Be at least 18 years of age.

*c.* Have experience in handling firearms and bows and arrows.

*d.* Have completed the course as defined in subrule 15.9(2).

*e.* Attend and pass an instructor's training and certification course administered by the department.

*f.* Submit to a background check. This check will include, but not be limited to, a criminal history check as provided by the department of public safety. A record of a felony conviction will disqualify the applicant.

*g.* Be disqualified, even if involved in an apprenticeship, if that person has accumulated any multiple offender points pursuant to rule 571—15.6(481A).

*h.* Successfully complete the apprenticeship as required in subrule 15.9(4).

**15.9(4)** *Instructor applicant apprenticeship.* Once an instructor applicant has met all of the criteria, as provided in subrule 15.9(3), the applicant will apprentice with a certified instructor until such time as the instructor applicant can satisfactorily perform all facets required of a certified instructor.

*a.* The minimum amount of time for an instructor applicant to apprentice will be the following:

Participation in three courses and attendance at one local instructor workshop as conducted by the recreational safety officer.

*b.* The recreational safety officer will make the determination as to which certified instructor will be supervising the instructor applicant during the apprenticeship.

*c.* The recreational safety officer will approve an instructor applicant for certification based upon the following:

(1) Successful completion of the minimum course requirements.

(2) Recommendation for certification from the supervising certified instructor.

(3) Lack of just cause objections from the local conservation officer(s), local chief instructor (if applicable), and the recreational safety coordinator.

**15.9(5)** *Certified hunter education instructor responsibilities.* A certified instructor has the following responsibilities.

*a.* To complete all prerequisites to becoming an instructor as provided in subrules 15.9(3) and 15.9(4).

*b.* To follow all policies and procedures as set forth in the current "Instructor Procedures Manual."

*c.* To assist in the recruitment and training of additional volunteer instructors.

*d.* To recruit and train students in the Iowa hunter education and ethics program.

*e.* To actively promote the program in the instructor's county and to arrange for publicity on each new class.

*f.* To maintain a file on all students that the instructor teaches.

*g.* To accurately fill out all required forms and reports for each class and mail that material to the recreational safety coordinator within 15 days after the completion of the course.

*h.* To teach the course as prescribed by the department.

*i.* To maintain order and discipline in the classroom, field, and firing line at all times.

*j.* To actively participate in one course every two years.

*k.* To attend a minimum of one continuing education instructor workshop as provided by the department every three years.

**15.9(6)** *Inactive instructors.* If a certified instructor fails to comply with paragraphs 571—15.9(5)*"j"* and 571—15.9(5)*"k,"* the certified instructor will be placed on inactive status.

*a.* The inactive instructor will not be allowed to conduct a course and certify students as long as the instructor is on inactive status.

*b.* The inactive instructor can be reactivated by attending an instructor certification workshop as provided by the department.

*c.* If an instructor remains inactive for a period of two years, that instructor will be required to turn in the instructor card to the department and will no longer be considered a certified hunter education instructor. The inactive instructor will be notified by the department regarding the termination of the instructor's certification.

**15.9(7)** *Grounds for revocation of instructor certification.* The department may, at any time, seek to revoke the instructor certification of any person who:

*a.* Fails to meet the instructor responsibilities as outlined in subrule 15.9(5).

*b.* Fails to follow the policies and procedures as set forth in the current "Instructor Procedures Manual."

*c.* Falsifies any information as may be required by the department.

*d.* Fails, after two notices, to provide the department with the required records of students trained and certificates of competency issued.

*e.* Handles any firearm or bow in an unsafe manner, or allows any other student or instructor to handle firearms or archery equipment in a reckless or unsafe manner.

*f.* Is convicted of or forfeits bond for any fish and game violation of this state or any other state.

*g.* Uses abusive or foul language while conducting a course.

*h.* Participates in a course while under the influence of alcohol or any illegal drugs.

*i.* Remains on the inactive instructor list for a period of five years or more.

*j.* Has substantiated complaints filed against the instructor by the public, department personnel, or other certified instructor(s).

*k.* Is convicted of a felony, aggravated or serious misdemeanor as defined in the statutes of this state. This would also include any felonies or comparable misdemeanors of any other state.

*l.* Receives compensation directly or indirectly from students for time spent on preparing for or participating in a course.

**15.9(8)** *Termination of certification.* Any certified instructor has the right, at any time, to voluntarily terminate certification. If an instructor terminates certification, voluntarily, or is terminated by the department, that instructor must return to the department the certification card and any and all materials that were provided.

**15.9(9)** *Compensation for instructors.* Instructor applicants and certified instructors shall not receive any compensation either directly or indirectly from students for their time while preparing for or participating in a course. However, instructor applicants and certified instructors may require students to pay for actual course-related expenses involving facilities and materials other than those provided by the department.

**15.9(10)** *Hearing rights.* If the department seeks to revoke an instructor certification pursuant to subrule 15.9(7), the department shall provide written notice of intent to revoke the certification as provided in 561—7.16(17A,455A). If the certified instructor requests a hearing, it shall be conducted in accordance with 561—Chapter 7.

This rule is intended to implement Iowa Code section 483A.27.

**571—15.10(483A,321G,462A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors and boating safety instructors.**

**15.10(1)** *Purpose.* Pursuant to Iowa Code sections 483A.27(4), 321G.23(2) and 462A.1, the department will certify volunteer instructors to teach the bow, fur harvester, snowmobile, ATV and boating education courses.

**15.10(2)** *Definitions.* For the purposes of this rule:

*"Certified instructor"* means a person who has met all criteria in this rule.

*"Course"* means the department's bow, fur harvester, snowmobile, ATV, and boating education courses.

*"Department"* means the Department of Natural Resources, Wallace State Office Building, Des Moines, Iowa 50319-0034.

*"Instructor applicant"* means a person who has applied to become a certified volunteer instructor for one of the above-named courses.

**15.10(3)** *Minimum qualifications.* The following conditions must be satisfied before any person can become a certified instructor. Failure to meet these conditions will result in the denial of the application. The instructor applicant will be notified of the denial by the recreational safety coordinator. An instructor applicant shall:

*a.* Submit an application as provided by the department to the local conservation officer or recreational safety officer.

*b.* Be at least 18 years of age.

*c.* Have experience in handling equipment that is necessary for the various prescribed courses such as firearms, bows and arrows, furbearer traps, snowmobiles, ATVs, and various navigational vessels.

*d.* Have completed the course as defined in subrule 15.10(2).

*e.* Attend and pass an instructor's training and certification course administered by the department.

*f.* Submit to a background check. This check will include, but not be limited to, a criminal history check as provided by the department of public safety. A record of a felony conviction will disqualify the applicant.

*g.* Be disqualified if the person has accumulated any habitual offender points pursuant to rule 571—15.6 (481A), or other license suspension by the court or department.

**15.10(4)** *Certified education instructor responsibilities.* A certified instructor has the following responsibilities:

*a.* To complete all prerequisites to becoming an instructor as provided in subrule 15.10(3).

*b.* To follow all policies and procedures as set forth in the current "Instructor Procedures Manual."

*c.* To assist in the recruitment and training of additional volunteer instructors.

*d.* To recruit and train students in the applied-for prescribed course program.

*e.* To actively promote the program in the instructor's county and to arrange for publicity on each new class.

*f.* To maintain order and discipline in the classroom and outdoor classroom at all times.

*g.* To accurately fill out all required forms and reports for each class and mail that material to the recreational safety coordinator within 15 days after the completion of the course.

*h.* To teach the course as prescribed by the department.

*i.* To maintain a file on all students that the instructor teaches.

*j.* To actively participate in one course every two years. If this requirement is not met, the instructor may be terminated after being notified by the recreational safety coordinator by letter.

**15.10(5)** *Grounds for revocation of instructor certification.* The department may, at any time, seek to revoke the instructor certification of any person who:

*a.* Fails to meet the instructor responsibilities as outlined in subrule 15.10(4).

*b.* Fails to follow the policies and procedures as set forth in the current "Instructor Procedures Manual."

*c.* Falsifies any information as may be required by the department.

*d.* Handles any equipment in an unsafe manner, or allows any other student or instructor to handle equipment in a reckless or unsafe manner.

*e.* Is convicted of or forfeits bond for any fish and game, snowmobile, ATV or navigation violation of this state or any other state.

*f.* Uses abusive or foul language while conducting a course.

*g.* Participates in a course while under the influence of alcohol or any illegal drugs.

*h.* Has substantiated complaints filed against the instructor by the public, department personnel or other certified instructor(s).

*i.* Fails to meet the requirement in 15.10(4)*"j."*

*j.* Is convicted of a felony, aggravated or serious misdemeanor as defined in the statutes of this state. This would also include any felonies or comparable misdemeanors of any other state.

*k.* Receives compensation directly or indirectly from students for time spent on preparing for or participating in a course.

**15.10(6)** *Termination of certification.* Any certified instructor has the right, at any time, to voluntarily terminate certification. If an instructor terminates certification voluntarily or is terminated by the department, that instructor must return to the department the certification card and any and all materials that were provided.

**15.10(7)** *Compensation for instructors.* Instructor applicants and certified instructors shall not receive any compensation either directly or indirectly from students for their time while preparing for or participating in a course. However, instructor applicants and certified instructors may require students to pay for actual course-related expenses involving facilities and materials other than those provided by the department.

**15.10(8)** *Hearing rights.* If the department seeks to revoke an instructor certification pursuant to subrule 15.10(5), the department shall provide written notice of intent to revoke the certification as provided in 561—7.16(17A,455A). If the certified instructor requests a hearing, it shall be conducted in accordance with 561—Chapter 7.

This rule is intended to implement Iowa Code sections 483A.27(4) and 321.23(2).

**571—15.11(483A) Transportation tags for military personnel on leave from active duty.**

**15.11(1)** *Military transportation tags for deer and turkey.* The military transportation tag shall include the following information: name, birth date, current address of military person; species and sex of animal taken; date of kill; and weapon used. Only conservation officers of the department shall be authorized to issue military transportation tags.

**15.11(2)** *Annual limit for military transportation tags.* A person receiving a military transportation tag shall be limited to one military deer tag and one military turkey tag annually.

**15.11(3)** *Regulations apply to military personnel.* With the exception of the license requirement exemption set forth in Iowa Code section 483A.24(6), all hunting and fishing regulations shall apply to active duty military personnel.

This rule is intended to implement Iowa Code section 483A.24(9).

**571—15.12(483A) Refunds or changes for special deer and turkey permits and general licenses.**

**15.12(1)** *Invalid applications.* Deer and turkey permit applications that are received too late for processing after the closing date for acceptance of applications or applications that are invalid on their face will be returned unopened to the applicant. Permit fees related to applications which are determined to be invalid by a computer analysis or other analysis after the applications have been processed will be refunded to the applicant, less a $10 invalid application fee to compensate for the additional processing cost related to an invalid application.

**15.12(2)** *Death of applicant.* Deer or turkey permit fees will be refunded to the applicant's estate when the permittee's death predates the season for which the permit was issued and a written request is received from the permittee's spouse, executor or estate administrator within 90 days of the last date for which the permit was issued.

**15.12(3)** *National or state emergency.* Deer or turkey permit fees will be refunded if the permittee is a member of the National Guard or a reserve unit and is activated for a national or state emergency which occurs during the season for which the permit was issued. A written refund request must be received by the DNR within 90 days of the last date of the season for which the permit was issued.

**15.12(4)** *Permit changes.* The agency will attempt to change an applicant's choice of season or type of permit if a written or telephonic request is received by the license bureau in sufficient time, usually 20 days, prior to printing the permit, and if the requested change does not result in disadvantage to another applicant. Telephonic change requests must be verified in writing by the requester before a change request will be honored. The agency's ability to accommodate requests to change season or permit type is dependent on workload and processing considerations. If the agency cannot accommodate a request to change a season or type choice, the permit will be issued as originally requested by the applicant. No refund will be allowed. The agency will not change the name on the permit from that submitted on the application.

**15.12(5)** *General hunting and fishing licenses duplicate purchase.* Upon a showing of sufficient documentation, usually a photocopy of the licenses, that more than one hunting or fishing license was purchased by or for a single person, the agency will refund the amount related to the duplicate purchase. A written refund request, with supporting documentation, must be received by the license bureau within 90 days of the date on the face of the duplicate licenses.

**15.12(6)** *Other refund requests.* Except as previously described, the agency will not issue refunds for any licenses, stamps or permits related to fishing and hunting.

This rule is intended to implement Iowa Code section 483A.9.

These rules are intended to implement Iowa Code sections 321.23(2), 481A.38 and 481A.134 and Iowa Code chapter 483A.

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# CHAPTER 29
# LOCAL RECREATION INFRASTRUCTURE GRANTS PROGRAM

**571—29.1(8,77GA,ch1219) Purpose.** The purpose of the local recreation infrastructure grants program is to provide state cost sharing to communities, counties, organizations and associations for the restoration or construction of recreational complexes or facilities.

The Iowa department of natural resources, hereinafter referred to as the department, will administer the local recreation infrastructure grants program.

**571—29.2(8,77GA,ch1219) Definitions.**

*"Commission"* means the natural resource commission created in Iowa Code section 455A.5.

*"Department"* means the department of natural resources created in Iowa Code section 455A.2.

*"Director"* means the director of the department of natural resources.

*"Infrastructure"* is defined in Iowa Code section 8.57(5c) as "vertical infrastructure" and includes only land acquisition and construction, major renovation and major repair of buildings, all appurtenant structures, utilities, site developments, and recreational trails.

**571—29.3(8,77GA,ch1219) Eligibility requirements.** Grants shall be awarded to local political subdivisions of the state and to any other established organization or association which is duly authorized and charged with responsibilities for construction, maintenance and operation of public recreation complexes and facilities. Private entities making application must demonstrate that they are acting on behalf of a public entity.

**571—29.4(8,77GA,ch1219) Assistance ceiling and cost share.** Grants to any individual project shall not exceed $100,000. Local project sponsors must provide local funding at the rate of two local dollars for each state grant dollar. Up to 50 percent of the local share may be a "soft match" in the form of donated labor, materials or land value. An appraisal must be approved by the department to serve as the basis for establishing the value of real property if used to provide soft match. Prevailing wage rates in the vicinity of the project shall serve as the basis for establishing the value of donated labor or services.

**571—29.5(8,77GA,ch1219) Minimum grant amount.** Applications for assistance totaling less than $2,500 will not be considered.

**571—29.6(8,77GA,ch1219) Grant application submission.**

**29.6(1)** *Form of application.* Grant applications shall be on forms and shall follow guidelines provided by the department. Completed applications shall provide sufficient detail as to clearly describe the scope of the project.

**29.6(2)** *Application timing.* Grant applications (one original and six copies) must be received in acceptable form by the Iowa Department of Natural Resources, Wallace State Office Building, Des Moines, Iowa 50319-0034, by the close of business on the first business day of September.

**29.6(3)** *Local funding.* An applicant shall certify that it has committed its share of project costs before the 90 percent up-front grant payment will be made. A "letter of intent" signed by the mayor, chairperson of the board of supervisors, chairperson of the county conservation board, or the CEO or chief financial officer of an agency or organization and submitted with the application showing intent to include funds in finalized budgets by March 15 will be accepted as proof of commitment. Applicants must forward proof of budgeting by April 1 or be removed from the list of approved projects.

**29.6(4)** *Similar development projects.* A single application for a development project grant may include development on more than one area if that development is of a like type.

**571—29.7(8,77GA,ch1219) Project review and selection.**

**29.7(1)** *Review and selection committee.* A review and selection committee, hereinafter referred to as the committee, comprised of six members appointed by the director, two representing cities, two representing counties, one representing other organizations or associations, and one having expertise in the vertical infrastructure industry shall review and evaluate project applications and shall develop funding recommendations to be forwarded to the natural resource commission for approval.

**29.7(2)** *Conflict of interest.* If a project is submitted to the review and selection committee by a city, county or other eligible sponsor, one of whose members or employees is on the review and selection committee, that individual shall not participate in discussion and shall not vote on that particular project.

**29.7(3)** *Consideration withheld.* The committee will not consider any application which, on the date of the selection session, is not complete or for which additional pertinent information has been requested and not received.

**29.7(4)** *Application rating system.* The committee will apply a numerical rating system to each grant application which is considered for fund assistance. The criteria, with a weight factor for each, shall include the following:

*a.* Public demand or need—weight factor of 2.

*b.* Quality of site or project—weight factor of 3.

*c.* Urgency of proposed project—weight factor of 2.

*d.* Multiple benefits provided, including economic benefits—weight factor of 3.

*e.* Conformance with local/regional and statewide plans—weight factor of 2.

*f.* Geographic distribution—weight factor of 1.

Each criterion shall be given a score from 1 to 10, which is then multiplied by the weight factor.

**571—29.8(8,77GA,ch1219) Rating system not used.** If total grant requests are less than the allotment available, the rating system will not be applied. All applications will be reviewed by the review and selection committee for eligibility to ensure they conform with the purpose of the program.

**571—29.9(8,77GA,ch1219) Applications not approved for funding.** Applications which have been considered but not approved for immediate funding or placed on the reserve list shall be returned to the applicants if requested.

**571—29.10(8,77GA,ch1219) Commission review.** The commission will review all committee recommendations as well as recommendations from the director and staff of the department at the first commission meeting following the review session. The commission may make alterations to the recommended priorities of projects and may reject any application recommended for funding or may approve any application not recommended by the committee or the director and staff. Reasons for change or rejection of any recommended project must be included in the motion to change the order or to reject any project. Commission action will result in three categories of projects: (1) approved for immediate funding; (2) approved for funding but placed on a reserve list to be funded from current funding cycle in the event that higher ranking projects fail to be implemented; and (3) disapproved for funding.

**571—29.11(8,77GA,ch1219) Grant amendments.** Project amendments may be made upon request by the applicant, subject to the availability of funds, and approval by the director.

**571—29.12(8,77GA,ch1219) Timely commencement of projects.** Grant recipients are expected to carry out their projects in an expedient manner. The project agreement signed by the sponsor and the director will include anticipated start-up and completion dates. Projects shall be initiated no later than July 1 following their approval by the commission and shall be completed within one year. Extensions must be approved by the director. Failure to initiate projects in a timely manner may be cause for termination of the agreement and cancellation of the grant.

**571—29.13(8,77GA,ch1219) Payments.** Ninety percent of approved grant amounts may be paid to project sponsors when requested, but not earlier than start-up of the project. Ten percent of the grant total shall be withheld by the department, pending successful completion and final site inspection, or until any irregularities discovered as a result of a final site inspection have been resolved.

**571—29.14(8,77GA,ch1219) Record keeping and retention.** Grant recipients shall keep adequate records relating to the administration of a project, particularly relating to all incurred expenses. These records shall be available for audit by representatives of the department and the state auditor's office. All records shall be retained in accordance with state laws.

**571—29.15(8,77GA,ch1219) Eligible projects.** Grants under this program are directed toward "vertical infrastructure" as defined in Iowa Code section 8.57(5c).

**571—29.16(8,77GA,ch1219) Project life and recovery of funds.** Applicants shall state an expected project life which will become part of the project agreement. Should the funded project cease to be used for public recreation before the stated project life, the director may seek to recover the remaining value of the grant award in the project.

**571—29.17(8,77GA,ch1219) Unlawful use of funds.** Whenever any property, real or personal, acquired or developed with grants under this program passes from the control of the grantee or is used for purposes other than the approved project purpose, it will be considered an unlawful use of the funds.

**571—29.18(8,77GA,ch1219) Remedy.** Funds used without authorization, for purposes other than the approved project purpose, or unlawfully must be returned to the department for deposit in the account supporting this program. In the case of diversion of personal property, the grantee shall remit to the department funds in the amount of the original purchase price of the property. The grantee shall have a period of two years after notification by the department in which to correct the unlawful use of funds. The remedy provided in this rule is in addition to others provided by law.

**571—29.19(8,77GA,ch1219) Ineligibility.** Whenever the director determines that a grantee is in violation of these rules, that grantee shall be ineligible for further assistance until the matter has been resolved to the satisfaction of the commission.

These rules are intended to implement Iowa Code section 8.57(5c) and 1998 Iowa Acts, chapter 1219, section 10.

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# CHAPTER 39
# BOATING PASSENGER CAPACITY

[Prior to 12/31/86, Conservation Commission[290] Ch 29]

**571—39.1(462A) U.S. Coast Guard capacity rating.** In the registration of vessels for which a U.S. Coast Guard capacity rating in whole persons has been assigned as evidenced by a U.S. Coast Guard capacity plate affixed to the vessel, that capacity shall be recognized as the registration capacity.

**571—39.2(462A) Vessels assigned a capacity rating by the manufacturer.** In the registration of vessels for which a U.S. Coast Guard capacity rating in whole persons has not been assigned but a plate has been affixed to the vessel containing capacity information, in whole persons, furnished by the boating industry association, national marine manufacturer association or any similar organization, that capacity shall be recognized as the registration capacity.

**571—39.3(462A) Vessels not containing capacity rating information.** In the registration of vessels for which no passenger capacity information has been provided by the U.S. Coast Guard or the manufacturer, the passenger capacity designated on the registration shall be O.R., "Operators Responsibility." The responsibility for determining passenger capacity of a vessel so designated shall rest with the operator of the vessel. Such operation must comply with the provisions of Iowa Code section 462A.12(1).

**571—39.4(462A) Incorrect registration.** When information contained on the registration certificate of a vessel is found to be incorrect regarding vessel length, vessel width, or passenger capacity, officers appointed by the department of natural resources may, upon inspection of the vessel, or the county recorder, upon presentation of adequate documentation including, but not limited to, an affidavit by the owner, may change the information on the certificate.

The officer shall within four days notify the department of natural resources and the county recorder of the county in which the vessel is registered of the changes on forms provided by the department of natural resources.

These rules are intended to implement Iowa Code sections 462A.20 and 462A.24.

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# CHAPTER 94
# NONRESIDENT DEER HUNTING

**571—94.1(483A) Licenses.** Every hunter must have in possession a valid deer license and proof that the hunter has paid the current year's wildlife habitat fee when hunting, possessing, or transporting deer. No person, while hunting deer, shall carry or have in possession any license or transportation tag issued to another person. No person shall obtain more than one nonresident deer hunting license.

**94.1(1)** *Bow season license.* Bow and arrow deer licenses shall be valid for any sex deer only during the bow season and zone designated.

**94.1(2)** *Regular gun season license.* Regular gun season licenses will be issued for antlered deer or any sex deer depending on the zone and the county or portions of counties within that zone in accordance with 571—subrule 106.5(1). Regular gun season licenses will be issued by zone and period and will be valid in the designated zone and for the designated period only. Any applicant who fails to designate the zone on the application form will not receive a license.

**94.1(3)** *Special muzzleloader season.* Special muzzleloader season licenses will be issued for antlered deer or any sex deer depending on the zone and the county or portions of counties within that zone in accordance with 571—subrule 106.5(1) and shall be valid only during the special muzzleloader season and zone designated.

**571—94.2(483A) Season dates.** Deer may be taken only during the following periods.

**94.2(1)** *Bow season.* Deer may be taken by bow and arrow only in accordance with the type, tenure, and zone of license issued from October 1 through the Friday before the first Saturday in December, and from the Monday following the third Saturday in December through January 10 of the following year.

**94.2(2)** *Regular gun season.* Deer may be taken with gun only in accordance with the type, tenure, and zone of license issued, from the first Saturday in December and continuing for five consecutive days or from the second Saturday in December and continuing for nine consecutive days.

**94.2(3)** *Special muzzleloader season.* Deer may be taken by muzzleloader only in accordance with the type, tenure, and zone of license issued from the Monday following the third Saturday in December through January 10 of the following year.

**571—94.3(483A) Shooting hours.** Legal shooting hours vary according to the type of season.

**94.3(1)** *Bow season.* Legal shooting hours for hunting deer with bow and arrow shall be one-half hour before sunrise to one-half hour after sunset each day.

**94.3(2)** *Regular gun season.* Legal shooting hours for hunting deer with a gun shall be sunrise to sunset each day.

**94.3(3)** *Special muzzleloader season.* Legal shooting hours for hunting deer during the special muzzleloader season shall be one-half hour before sunrise to one-half hour after sunset each day.

**571—94.4(483A) Limits.**

**94.4(1)** *Bow season.* Daily bag limit one deer; possession limit one deer.

**94.4(2)** *Regular gun seasons.* Bag limit shall be one deer for each hunter in the party who has a valid deer transportation tag. Possession limit shall be one deer per license; "possession" shall mean that the deer is in possession of the person whose license number matches the number of the transportation tag on the carcass of the deer.

**94.4(3)** *Muzzleloader season.* Daily bag limit one deer; possession limit one deer.

**94.4(4)** *Maximum annual possession limit.* The maximum annual possession limit is one deer.

**571—94.5(483A) Zones open to hunting.** Licenses will be valid only in designated areas as follows:

**94.5(1)** *Zone descriptions.* The zones are described as areas bounded as follows:

*a.* *Zone 1.* Beginning at a point where U.S. Highway 169 crosses the Minnesota-Iowa state line; thence along U.S. Highway 169 to state Highway 3; thence along state Highway 3 to U.S. Highway 71; thence along U.S. Highway 71 to U.S. Highway 20; thence along U.S. Highway 20 to the Nebraska-Iowa state line; thence along the Nebraska-Iowa, South Dakota-Iowa and Minnesota-Iowa state lines to the point of beginning.

*b.* *Zone 2.* Beginning at the point where state Highway 3 and Interstate Highway 35 intersect; thence along Interstate Highway 35 to its eastern junction with Interstate Highways 80 and 235; thence along Interstate Highway 235 to its western junction with Interstate Highways 80 and 35; thence along Interstate Highway 80 to U.S. Highway 59; thence along U.S. Highway 59 to U.S. Highway 20; thence along U.S. Highway 20 to U.S. Highway 71; thence along U.S. Highway 71 to state Highway 3; thence along state Highway 3 to the point of beginning.

*c.* *Zone 3.* Beginning at the point where U.S. Highway 20 crosses the Nebraska-Iowa state line; thence along U.S. Highway 20 to U.S. Highway 59; thence along U.S. Highway 59 to the Missouri-Iowa state line; thence along the Missouri-Iowa and Nebraska-Iowa state lines to the point of beginning.

*d.* *Zone 4.* Beginning at the western junction of Interstate Highway 235 with Interstate Highways 80 and 35; thence along Interstate Highway 35 to the Missouri-Iowa state line; thence along the Missouri-Iowa state line to U.S. Highway 59; thence along U.S. Highway 59 to Interstate Highway 80; thence along Interstate Highway 80 to the point of beginning.

*e.* *Zone 5.* Beginning at the point where Interstate Highway 235 and state Highway 163 intersect; thence along state Highway 163 to state Highway 92; thence along state Highway 92 to U.S. Highway 218; thence along U.S. Highway 218 to U.S. Highway 34; thence along U.S. Highway 34 to U.S. Highway 63; thence along U.S. Highway 63 to the Missouri-Iowa state line; thence along the Missouri-Iowa state line to Interstate Highway 35; thence along Interstate Highway 35 to its western junction with Interstate Highways 80 and 235; thence along Interstate Highway 235 to the point of beginning.

*f.* *Zone 6.* Beginning at the point where U.S. Highway 63 crosses the Missouri-Iowa state line; thence along U.S. Highway 63 to U.S. Highway 34; thence along U.S. Highway 34 to U.S. Highway 218; thence along U.S. Highway 218 to state Highway 92; thence along state Highway 92 to the Illinois-Iowa state line; thence along the Illinois-Iowa and Missouri-Iowa state lines to the point of beginning.

*g.* *Zone 7.* Beginning at the point where U.S. Highway 61 intersects with state Highway 92 at its northern junction; thence along state Highway 92 to state Highway 163; thence along state Highway 163 to Interstate Highway 235; thence along Interstate Highway 235 to its eastern junction with Interstate Highways 80 and 35; thence along Interstate Highway 35 to state Highway 3; thence along state Highway 3 to state Highway 38; thence along state Highway 38 to U.S. Highway 61; thence along U.S. Highway 61 to the point of beginning.

*h.* *Zone 8.* Beginning at the point where state Highway 92 intersects with the Illinois-Iowa state line; thence along state Highway 92 to U.S. Highway 61; thence along U.S. Highway 61 to state Highway 38; thence along state Highway 38 to state Highway 3; thence along state Highway 3 to the Illinois-Iowa state line; thence along the Illinois-Iowa state line to the point of beginning.

*i.* *Zone 9.* Beginning at the point where state Highway 3 intersects with the Illinois-Iowa state line; thence along state Highway 3 to U.S. Highway 63; thence along U.S. Highway 63 to the Minnesota-Iowa state line; thence along the Minnesota-Iowa, Wisconsin-Iowa, and Illinois-Iowa state lines to the point of beginning.

*j.* *Zone 10.* Beginning at the point where U.S. Highway 63 crosses the Minnesota-Iowa state line; thence along U.S. Highway 63 to state Highway 3; thence along state Highway 3 to U.S. Highway 169; thence along U.S. Highway 169 to the Minnesota-Iowa state line; thence along the Minnesota-Iowa state line to the point of beginning.

**94.5(2)** *Bow season.* Bow and arrow deer licenses will be valid only in the zone designated on the license.

**94.5(3)** *Regular gun season.* Regular gun season deer licenses will be valid only in the zone designated on the license.

**94.5(4)** *Special muzzleloader season.* Special muzzleloader deer licenses will be valid only in the zone designated on the license.

**94.5(5)** *Closed areas.* There shall be no open season for hunting deer on the county roads immediately adjacent to or through Union Slough National Wildlife Refuge, Kossuth County, where posted accordingly.

**571—94.6(483A) License quotas.** A limited number of deer licenses will be issued in zones as follows:

**94.6(1)** *Zone license quotas.* Nonresident license quotas are as follows:

| | Any Sex | | Antlerless |
|---|---|---|---|
| | All Methods | Bow | |
| Zone 1. | 240 | 84 | |
| Zone 2. | 240 | 84 | |
| Zone 3. | 600 | 210 | |
| Zone 4. | 1200 | 420 | |
| Zone 5. | 1500 | 525 | |
| Zone 6. | 780 | 273 | |
| Zone 7. | 360 | 126 | |
| Zone 8. | 240 | 84 | |
| Zone 9. | 600 | 210 | |
| Zone 10. | 240 | 84 | |
| Total | 6000 | 2100 | 1500 statewide |

**94.6(2)** *Quota applicability.* The license quota issued for each zone will be the quota for all bow, regular gun and special muzzleloader licenses combined. No more than 6,000 any sex licenses will be issued for all methods of take combined, for the entire state. Of the 6,000 licenses, no more than 35 percent in any zone can be bow licenses. A maximum of 1,500 antlerless-only licenses, regardless of weapon, will be issued for the entire state.

**571—94.7(483A) Method of take.** Permitted weapons and devices vary according to the type of season.

**94.7(1)** *Bow season.* Except as provided in 571—15.5(481A), only recurve, compound or longbows with broadhead arrows will be permitted in taking deer during the bow season. Arrows with chemical or explosive pods are not permitted.

**94.7(2)** *Regular gun season.* Only 10-, 12-, 16-, or 20-gauge shotguns, shooting single slugs only, and flintlock or percussion cap lock muzzleloaded rifles or muskets of not less than .44 nor larger than 775 caliber, shooting single projectiles only, will be permitted in taking deer during the regular gun season.

**94.7(3)** *Special muzzleloader season.* Flintlock or percussion cap lock muzzleloaded rifles or muskets of not less than .44 nor larger than .775 caliber, shooting single projectiles only, bows as described in 94.7(1), and handguns as described in 106.7(3), will be permitted in taking deer during the special muzzleloader seasons.

**94.7(4)** *Prohibited weapons and devices.* The use of dogs, domestic animals, salt or bait, rifles other than muzzleloaded, handguns except as provided in 94.7(3), crossbows except as otherwise provided, automobiles, aircraft, or any mechanical conveyances or device including electronic calls is prohibited except that paraplegics and single or double amputees of the legs may hunt from any stationary motor-driven land conveyance. "Bait" means grain, fruit, vegetables, nuts, hay, salt or mineral blocks or any other natural food materials, or by-products of such materials transported to or placed in an area for the intent of attracting wildlife. Bait does not include food placed during normal agricultural activities. "Paraplegic" means an individual with paralysis of the lower half of the body with involvement of both legs, usually due to disease of or injury to the spinal cord.

It shall be unlawful for a person, while hunting deer, to have on their person a handgun except as provided in 94.7(3) or rifle other than a muzzleloading rifle that meets the requirements of 571—subrule 106.7(3).

**94.7(5)** *Discharge of firearms from highway.* No person shall discharge a shotgun shooting slugs or muzzleloader from a highway during the regular gun seasons in all counties and parts of counties north of Highway 30 and west of Highway 63. A "highway" means the way between property lines open to the public for vehicle traffic as defined in Iowa Code section 321.1(78).

**571—94.8(483A) Application procedures.** All applications for nonresident deer hunting licenses shall be made on forms provided by the department of natural resources and returned to the department of natural resources office in Des Moines, Iowa. No one shall submit more than one application. Applications for nonresident deer hunting licenses must be accompanied by the appropriate license fee. The nonresident license fee shall be $150.50. Party applications with no more than four individuals will be accepted. Applications received in the natural resources office in Des Moines, Iowa, by 4:30 p.m. on the second Friday in June will be processed. If applications received are in excess of the license quota for any hunting zone, a drawing will be conducted to determine which applicants shall receive licenses. If licenses are still available in any zone, licenses will be issued as applications are received until quotas are filled or the last Friday in September, whichever occurs first. Any incomplete or improperly completed application or any application not meeting the above conditions will not be considered as a valid application.

The department may develop media/telecommunication options that would allow for additional methods of obtaining a deer license. Methods and deadlines may be determined by the department as a part of the alternative methods developed.

**571—94.9(483A) Transportation tag.** A transportation tag bearing the license number of the licensee, year of issuance, and date of kill properly shown shall be visibly attached to the carcass of each deer, in such a manner that the tag cannot be removed without mutilating or destroying the tag, within 15 minutes of the time the deer is killed or before the carcass of the deer is moved in any manner, whichever first occurs. This tag shall be proof of possession and shall remain affixed to the carcass until such time as the animal is processed for consumption. The head, and antlers if any, shall remain attached to all deer while being transported by any means whatsoever from the place where taken to the processor or commercial preservation facility, or until the deer has been processed for consumption.

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.48, 483A.1 and 483A.8.

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# CHAPTER 95
# NONRESIDENT WILD TURKEY FALL HUNTING

Rescinded, IAB 5/30/90, effective 7/4/90

See 571—Chapter 99

40.36(151) Acupuncture
40.37(151) Nonprofit nutritional product sales
40.38(151) Chiropractic insurance consultant
40.39(151) Adjunctive procedures
40.40(151) Physical examination
40.41(151) Gonad shielding
40.42 to 40.46 Reserved

DISCIPLINARY PROCEDURE

40.47(17A,147,151,272C) Disciplinary procedure
40.48 to 40.50 Reserved

PRINCIPLES OF PROFESSIONAL ETHICS

40.51(147,272C) Principles of chiropractic ethics

PROCEDURES FOR USE OF CAMERAS AND RECORDING DEVICES AT OPEN MEETINGS

40.52(151,272C) Conduct of persons attending meetings
40.53 to 40.60 Reserved

CONTINUING EDUCATION

40.61 Reserved
40.62(272C) Continuing education requirements
40.63(151) Standards for approval
40.64(151) Approval of sponsors, programs, and activities
40.65(272C) Hearings
40.66(272C) Reports and records
40.67(272C) Attendance record
40.68 Reserved
40.69(272C) Exemptions for inactive practitioners
40.70(272C) Reinstatement of inactive practitioners
40.71(272C) Exemptions for active practitioners
40.72(272C) Physical disability, illness or exemption of continuing education
40.73(272C) Reinstatement of lapsed license

CHAPTER 41
CHILD SUPPORT NONCOMPLIANCE

41.1(252J) Definitions

CHAPTER 42
IMPAIRED PRACTITIONER REVIEW COMMITTEE

42.1(272C) Impaired practitioner review committee

CHAPTERS 43 to 48
Reserved

CHAPTER 49
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

49.1(17A,22) Definitions
49.14(17A,22) Personally identifiable information

CHAPTERS 50 to 59
Reserved

*COSMETOLOGY*

CHAPTER 60
LICENSURE OF COSMETOLOGISTS, ELECTROLOGISTS, ESTHETICIANS, MANICURISTS, NAIL TECHNOLOGISTS, AND INSTRUCTORS OF COSMETOLOGY ARTS AND SCIENCES

60.1(157) Definitions
60.2(157) Requirements for licensure to practice cosmetology
60.3(157) Licensure of applicants licensed in cosmetology arts and sciences in other states and countries
60.4(157) Cosmetology arts and sciences examination
60.5(157) Requirements for license to practice electrology

60.6(157) Requirements for license to practice esthetics
60.7(157) Requirements for license to practice manicuring
60.8(157) Requirements for license to practice nail technology
60.9(157) Core life sciences curriculum
60.10(157) Requirements for instructor's license
60.11(157) Temporary permits
60.12(157) Reinstatement of inactive (exempt) practitioners of cosmetology arts and sciences
60.13(272C) Reinstatement of lapsed license
60.14(157) Display of license
60.15(157) Notification of change of name or mailing address

CHAPTER 61
LICENSURE OF SALONS AND SCHOOLS OF COSMETOLOGY ARTS AND SCIENCES

61.1(157) Salon licensing
61.2(157) School of cosmetology arts and sciences—licensing
61.3(157) Courses of study
61.4(157) Instructors
61.5(157) Salons shall not be operated in connection with the school
61.6(157) Students

CHAPTER 62
FEES

62.1(147,157) All fees are nonrefundable

CHAPTER 63
REQUIREMENTS FOR SALONS AND SCHOOLS OF COSMETOLOGY ARTS AND SCIENCES

63.1(157) Rules and inspection reports
63.2(157) License
63.3(157) Proper quarters
63.4(157) Sanitation
63.5(157) Particular aspects of sanitizing
63.6(157) Water
63.7(157) Laundry and storage facilities
63.8(157) Work stands
63.9(157) Pets
63.10(157) Clients
63.11(157) Records
63.12(157) Electrology requirements and sanitation
63.13(157) Violations

CHAPTER 64
COSMETOLOGY ARTS AND SCIENCES CONTINUING EDUCATION

64.1(272C) Continuing education requirements
64.2(272C) Report of licensee
64.3 Reserved
64.4(272C) Physical and mental disability or illness
64.5(272C) Exemptions for inactive licensees
64.6(272C) Standards for approval
64.7(272C) Approval of sponsors
64.8 Reserved

CHAPTER 65
DISCIPLINARY PROCEDURES FOR COSMETOLOGY ARTS AND SCIENCES LICENSEES

65.1(272C) Complaint
65.2(272C) Report of malpractice claims or actions
65.3(272C) Investigation of complaints or malpractice claims
65.4(272C) Alternative procedure
65.5(272C) License denial
65.6(272C) Notice of hearing
65.7(272C) Hearings open to public
65.8(272C) Hearings
65.9(272C) Appeal
65.10(272C) Transcript

*d.* Submit application and fees; certification of completion of instructor's training from school of cosmetology arts and sciences or proof of two years' active practice in the field of cosmetology arts and sciences; and proof of attendance at an advanced instructor's institute prescribed by the board, prior to the starting date of employment as an instructor by a school of cosmetology arts and sciences.

*e.* The department shall issue to the applicant a notice of registration which shall be displayed for public view. Such notice shall be valid for 12 months.

*f.* Pass an instructor's and Iowa law examination within the first 12 months of employment to receive the original instructor's license.

*g.* Notwithstanding paragraph *"b,"* an instructor teaching courses in electrology, esthetics and nail technology shall hold a current license in the practice and possess an instructor license to teach that practice or be a licensed cosmetology instructor who possesses the skill and knowledge required to instruct in that practice.

*h.* An instructor teaching courses in electrology shall have 60 hours of practical application experience, excluding school hours, in the area of electrolysis prior to application. The 60 hours must be documented by the employer.

**60.10(2)** Reserved.

**645—60.11(157) Temporary permits.**

**60.11(1)** *Trainee permit.* A person who completes the requirements for licensure listed in Iowa Code section 157.3, except for the examination, shall be known as a trainee and, upon request, the department shall issue a temporary permit which allows the applicant to practice in the cosmetology arts and sciences, under the supervision of a licensee of cosmetology arts and sciences, barber, or person holding the same license in cosmetology arts and sciences, from the date of application until passage of the examination subject to that practice. An applicant shall take the first available examination administered by the board and may retain the temporary permit if the applicant does not pass the first examination. An applicant who does not pass the first examination shall take the next available examination administered by the board. The temporary permit of an applicant who does not pass the second examination shall be revoked.

**60.11(2)** *Demonstrator's permit.* The department may issue a demonstrator's permit for the purpose of demonstrating cosmetology arts and sciences to the consuming public upon recommendation of the board. The board shall determine and state its recommendations and the length of time the temporary permit is valid.

*a.* A demonstrator permit shall be valid for a salon, or person. The location, purpose and duration shall be stated on the permit.

*b.* A demonstrator permit shall be applied for at least 30 days in advance of dates of intended use.

*c.* A demonstrator permit shall be issued for from one to ten days.

*d.* The application shall be accompanied by the fee as set forth in 645—subrule 62.1(15).

*e.* No more than four permits shall be issued to any applicant during a calendar year.

**645—60.12(157) Reinstatement of inactive (exempt) practitioners of cosmetology arts and sciences.** Inactive practitioners who have requested and been granted a waiver of compliance with the renewal requirements as outlined in 645—64.5(272C) or Iowa Code chapter 157 or 272C and who have obtained a certificate of exemption shall, prior to engaging in the practice of the profession in Iowa, satisfy the following requirements for reinstatement:

**60.12(1)** Submit written application for reinstatement to the board upon forms provided by the boards; and

**60.12(2)** Furnish in the application evidence of one of the following:

*a.* Verification of current active licensure in another state of the United States or the District of Columbia and a notarized statement of active practice of 12 months during the 24 months preceding application for reinstatement of Iowa license. If exempt four years or more, the person shall pass the Iowa Law Examination; or

*b.* Completion of a total number of hours of approved continuing education computed by multiplying four hours by the number of years, to a maximum of four years, or completion of a refresher course through a licensed Iowa school of cosmetology. If exempt four years or more, the person shall pass the Iowa Law Examination (see 645—subrule 64.7(1)); or

*c.* Successful completion of the Iowa state license examination conducted within one year immediately prior to the submission of such application for reinstatement.

**60.12(3)** Submit reinstatement fee equivalent to two renewal periods.

**645—60.13(272C) Reinstatement of lapsed license.**

**60.13(1)** Those persons who have failed to renew a license to practice issued by the department pursuant to Iowa Code chapter 157 and who have not previously received a certificate of exemption shall:

*a.* For a lapsed cosmetology arts and sciences license, pay past due renewal and penalty fees in addition to completion of all past due continuing education to a maximum of four years. If lapsed four years or more, the person shall complete a refresher course approved by the board and retake the practical and Iowa law portions of the state board examination.

EXCEPTION: A person applying for reinstatement of a license which has lapsed for four years or more who can show proof of current licensure in another state and active practice for 12 out of 24 months preceding submission of the application for reinstatement will not be required to take the brush-up course, continuing education hours and practical portion of the examination; however, they will be required to successfully complete the Iowa law examination. Proof of current licensure would be shown by a certification of licensure with a raised state seal from the state in which the applicant is licensed. Proof of active practice would be shown by notarized statements from previous employers.

*b.* For a lapsed manicuring license, pay past renewal and penalty fees in addition to completion of all past due continuing education to a maximum of four years and pass the Iowa law examination.

*c.* For a lapsed instructor license, pay past renewal and penalty fees to a maximum of four years, take a Micro Teaching Technical Skills Institute course, and pass the instructor and Iowa law examinations within six months of date of reinstatement.

**60.13(2)** Rescinded IAB 12/4/96, effective 1/8/97.

**645—60.14(157) Display of license.** The original practitioner's license and renewal or trainee permit shall be displayed in the licensee's primary place of practice. Following the first renewal, a wallet-sized duplicate license, obtained from the department, shall be available at all satellite places of practice upon request by a client or inspector.

**645—60.15(157) Notification of change of name or mailing address.**

**60.15(1)** Each licensee or trainee shall notify the department of a change of the licensee's mailing address within 30 days after change.

**60.15(2)** Each licensee or trainee shall notify the department of a change of the licensee's name within 30 days after change.

These rules are intended to implement Iowa Code sections 147.29, 147.36, 147.44 to 147.49, 157.3, 157.4, 157.5, and Iowa Code chapter 272C.

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[illegible]

# CHAPTER 63
# REQUIREMENTS FOR SALONS AND SCHOOLS OF COSMETOLOGY ARTS AND SCIENCES

[Prior to 7/29/87, Health Department[470] Chs 149, 150]
[Prior to IAC 12/23/92, see 645—Chapters 60, 61]

**645—63.1(157) Rules and inspection reports.** The owner or manager of every salon or school of cosmetology arts and sciences shall keep a copy of the rules of sanitation adopted by the Iowa department of public health and of the most recent inspection report posted in a conspicuous place for the information and guidance of all persons employed or studying therein and the public generally.

**645—63.2(157) License.** The original license, duplicate license or temporary permit, and the current renewal certifying that the practitioner is licensed or a trainee certified by the board shall be visibly displayed for each licensee. Salon and school of cosmetology arts and sciences licenses along with the current renewal shall be posted visible to the public therein.

**645—63.3(157) Proper quarters.**

**63.3(1)** A salon shall not be maintained in a home unless a separate room is provided for that purpose. The room(s) designated as the salon shall not be permitted licensure unless it has direct ingress and egress from the outside of the residence. An exception to this rule is that an entrance may be through a nonliving area of the residence, i.e., hall, garage or stairway; in such an exception, any doors leading to the living quarters from said salon shall be closed during business hours. Any door leading directly from the licensed salon to any portion of the living area of the residence shall be closed at all times during business hours.

**63.3(2)** Salons operated in connection with any other business, except where food is handled, shall be separated by at least a partial partition. Should the salon be operated immediately adjacent to a business where food is handled, such establishment shall be entirely separated and any doors between the aforesaid shall be rendered unusable except in an emergency.

**63.3(3)** Each salon shall include a clinical, dispensary and reception area.

**63.3(4)** All establishments shall be kept well-lighted with at least 10 foot candlepower of natural or artificial light present at all work stations. All areas shall be well-lighted.

**63.3(5)** All establishments shall be adequately ventilated. Special precautions must be taken when providing artificial nail services.

**63.3(6)** Toilet facilities shall be provided and made available and easily accessible within the building. They shall be maintained in sanitary condition. Soap or other cleansing agent must be available and individual cloth, paper towels or air blowers for drying hands must be provided. The common towel is strictly prohibited and the presence of same shall be prima facie evidence of its use.

**63.3(7)** A salon owner or supervisor may designate a smoking area, but a salon in its entirety may not be a designated smoking area. Signs must be posted indicating smoking and nonsmoking areas.

*a.* An entire salon may be designated as a nonsmoking area.

*b.* No person shall smoke or carry lighted smoking materials in a nonsmoking area or where flammable materials are being handled or dispensed.

*c.* The clinic area of all salons and schools of cosmetology arts and sciences shall be designated nonsmoking areas.

*d.* The dispensary area of all salons and schools of cosmetology arts and sciences shall be designated nonsmoking areas.

**645—63.4(157) Sanitation.**

**63.4(1)** All salons and schools of cosmetology arts and sciences shall be kept in a sanitary condition.

**63.4(2)** If a premises houses more than one licensed salon, the cleanliness and sanitary conditions of any common areas are the responsibility of each license holder and any violation found in the common area will be cited against all licensees occupying the premises.

**63.4(3)** Every licensee, trainee or student engaged in serving the public shall be neat and clean in person and attire.

**63.4(4)** All licensees and students shall wash their hands with soap and water immediately before serving each patron.

**63.4(5)** Hair clippings shall not be allowed to accumulate and should be disposed of after each service.

**63.4(6)** The UNIVERSAL PRECAUTIONS are a set of guidelines which all students and licensees shall employ consistently with all clients to prevent exposure to blood-borne pathogens and the transmission of disease.

*a.* Place used needles, razor blades and other sharp instruments in a puncture-resistant container for disposal. Locate these containers as close to the use area as is practical.

*b.* Disposable gloves shall be worn to prevent exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply.

*c.* Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply.

*d.* Licensees and students who have weeping dermatitis or draining lesions should refrain from all direct client care and from handling client-care equipment until the condition has cleared.

**63.4(7)** Definitions and terms for infection control practices:

*a.* Sterilization: a procedure that kills all microorganisms, including their spores.

*b.* Disinfection: a procedure that kills pathogenic microorganisms, but not necessarily their spores. Chemical germicides which are formulated as disinfectants are used on inanimate surfaces and should not be used on skin or tissue.

*c.* Sterilizer or sterilant: an agent intended to destroy all microorganisms—viruses, bacteria, fungi, and their spores on inanimate objects.

*d.* Disinfectant: an agent intended to destroy or irreversibly inactivate specific viruses, bacteria, or pathogenic fungi, but not necessarily their spores, on inanimate surfaces. Most disinfectants are not effective sterilants.

*e.* Antiseptic: a chemical germicide formulated to be used on skin or tissue. Antiseptics should not be used as disinfectants.

*f.* Germicide: a general term indicating an agent that kills pathogenic microorganisms.

*g.* Decontamination: a procedure that eliminates or reduces microbial contamination to a safe level with respect to transmission of infection. Sterilization and disinfection procedures are often used for decontamination.

*h.* Sanitization: a procedure that reduces the level of microbial contamination so that the item or surface is considered safe.

**63.4(8)** Classification of instruments and implements:

*a.* Critical: instruments and objects that are directly introduced into the bloodstream or into other normally sterile areas of the body.

*b.* Semicritical: instruments and objects that come in contact with intact mucous membranes and do not ordinarily penetrate body surfaces.

*c.* Noncritical: instruments and objects that do not ordinarily touch the client or those that contact only intact skin.

**63.4(9)** All instruments or implements classified as critical shall be sterilized following each use.

*a.* All liquid sterilants must be EPA-registered, hospital-grade, bactericidal, virucidal, fungicidal and tuberculocidal. They should be used strictly in accordance with manufacturers' instructions for mixing and immersion.

*b.* Moist heat (steam under pressure) shall be 250 degrees F (121 degrees C), or above, prevacuum cycle, 271 degrees F (132 degrees C).

*c.* Dry heat shall be 171 degrees C for 1 hour; 160 degrees C for 2 hours; 121 degrees C for 16 hours or longer.

*d.* All sterilized instruments shall be stored in an airtight container or a liquid sterilant until ready for use.

**63.4(10)** All instruments or implements classified as semicritical shall be disinfected following each use.

*a.* All liquid disinfectants must be EPA-registered, hospital-grade, bactericidal, virucidal, fungicidal and tuberculocidal. They should be used strictly in accordance with manufacturers' instructions for mixing and immersion.

*b.* Moist heat shall be at 75-100 degrees C used at a high activity level.

**63.4(11)** All instruments or implements classified as noncritical shall be disinfected following each use.

**63.4(12)** All disinfected semicritical and noncritical implements shall be stored in a disinfected, dry covered container until ready for use.

**63.4(13)** Each work station shall have:

*a.* A closed container for all contaminated implements and instruments.

*b.* A closed container for all disinfected implements and instruments.

*c.* A closed container containing a liquid disinfectant for contaminated implements.

**63.4(14)** Disinfectants and sterilants as described above shall be available for immediate use at all times in a salon or school of cosmetology arts and sciences that is in operation.

**63.4(15)** Any disposable material that would release blood or other potentially infectious materials in a liquid or semiliquid state if compressed, shall be placed in a red hazardous waste bag and disposed of in accordance with regulation for removal of hazardous waste.

**63.4(16)** Any disposable sharp objects that come in contact with blood or other body fluids shall be disposed of in a red sealable rigid container (punctureproof) that is clearly labeled for disposal of hazardous waste sharps.

**63.4(17)** Hazardous waste containers and bags shall be available for use at all times when services are being performed. Absence of containers shall be prima facie evidence of noncompliance.

**63.4(18)** Emery boards, cosmetic sponges, applicators and orangewood sticks must be discarded after each use or given to the client.

**645—63.5(157) Particular aspects of sanitizing.**

**63.5(1)** Any material used to stop the flow of blood shall be used in liquid or powder form. The use of a styptic pencil is strictly prohibited; its presence in the workplace shall be prima facie evidence of its use.

**63.5(2)** All fluids, semifluids and powders must be dispensed with a shaker, dispenser pump or spray-type container. All creams, lotions and other cosmetics used for patrons must be kept in closed containers and dispensed with disposable applicators.

**63.5(3)** The use of nail buffers or neck dusters is strictly prohibited. Presence of these articles in the workplace shall be prima facie evidence of use.

**63.5(4)** Head lice may be treated in the salon or school at the discretion of the licensed cosmetologist or instructor of cosmetology arts and sciences. Compliance with all applicable laws and rules shall be required.

**63.5(5)** All consumers must be protected from direct skin contact with multiuse capes or covers, by single-use towels, or paper neck strips. Neck strips must be disposed of immediately after use. All consumers must be protected with a nonabsorbent cover during chemical application.

**63.5(6)** Licensees and students shall wear disposable gloves while working on a client if blood, pus or weeping is present or likely to occur. Gloves shall be disposed of after single use.

**63.5(7)** Licensees, salon owners and supervisors shall comply with all relevant federal and state workplace safety laws including all relevant requirements of federal and state hazard communication standards.

**63.5(8)** All sharp or pointed equipment shall be stored when not in use so as not to be readily available to consumers.

**63.5(9)** All heat-producing appliances must be stored in proper containers in a sufficiently ventilated, safe area.

**63.5(10)** Each licensee and salon owner shall comply with all other applicable state regulations pertaining to public health and safety.

**645—63.6(157) Water.** Every salon or school of cosmetology arts and sciences shall be supplied with an adequate supply of potable hot and cold water under pressure.

**645—63.7(157) Laundry and storage facilities.** All salons and schools of cosmetology arts and sciences must maintain an adequate supply of sanitized linen for proper operation.

**63.7(1)** All sanitized linen must be kept in an enclosed, dustproof cabinet until used.

**63.7(2)** Any towel that has been used once shall be considered soiled and shall be placed in a closed receptacle until properly laundered and sanitized.

**63.7(3)** Freshly laundered towels shall be used for each client.

**645—63.8(157) Work stands.** All work stands shall be covered with nonabsorbent, washable material.

**63.8(1)** All bottles, jars, receptacles, compartments and containers of all kinds shall be properly labeled at all times.

**63.8(2)** All equipment shall be maintained in a sanitary condition.

**645—63.9(157) Pets.** No pets of any kind shall be permitted in a salon or school of cosmetology arts and sciences except guide dogs and fish in an aquarium.

**645—63.10(157) Clients.** Licensees in serving the public may exercise reasonable discretion in accepting clients in their practice; however, licensees shall not refuse to accept clients into their practice or deny service to clients because of the client's race, creed, age, sex or national origin.

**645—63.11(157) Records.** Client records and appointment records shall be maintained for a period of no less than three years following the last date of entry. Proper safeguards shall be provided to ensure the safety of these records from destructive elements.

EXCEPTION: A school of cosmetology arts and sciences is not required to maintain appointment records for any required period of time. However, the client records shall indicate the date of service and identify the student rendering the service.

**645—63.12(157) Electrology requirements and sanitation.** A salon in which electrology is practiced shall follow all sanitation rules and requirements pertaining to all salons and shall also follow these requirements:

**63.12(1)** Electrology room shall have adequate space, lighting and ventilation.

**63.12(2)** Floors in the immediate area where the electrology is performed shall have an impervious, smooth, washable surface.

**63.12(3)** All service table surfaces shall be constructed of impervious, easily cleanable material.

**63.12(4)** Razors shall be single-client use and disposable or shall be sterilized razors with a new blade used for each client.

**645—63.13(157) Violations.** If a violation of Iowa Code or these rules is detected within a premises owned or leased by or affiliated with the licensee in any way, then the violation shall be cited against the licensee.

These rules are intended to implement Iowa Code sections 147.7, 147.46, 157.6 and 157.14.

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# CHAPTER 64
# COSMETOLOGY ARTS AND SCIENCES CONTINUING EDUCATION

[Prior to 7/29/87, Health Department[470] Ch 151]
[Prior to 12/23/92, see 645—Chapter 62]

**645—64.1(272C) Continuing education requirements.**

**64.1(1)** With the continuing education compliance period beginning April 1, 2000, continuing education requirements are as follows:

*a.* For each cosmetology arts and sciences license held, the licensee shall complete during each license renewal period a minimum of eight hours of continuing education approved by the board, of which at least four hours shall be in the area of the prescribed practice discipline.

*b.* In addition to fulfilling the requirements of 64.1(1)"*a*," those persons holding an instructor's license must complete a minimum of eight hours of continuing education approved by the board in the area of teaching methodology.

*c.* Compliance with the requirement of continuing education is a prerequisite for license renewal in the next license period.

**64.1(2)** The license renewal period shall consist of a period of two years, from April 1 of one year to March 31 of the second year following. All licensees shall renew on a biennial basis.

*a.* Half of the cosmetology arts and sciences licensees shall renew for the period of April 1 of an even-numbered year to March 31 of the next even-numbered year. This group of cosmetology arts and sciences licensees shall be designated as "A's."

*b.* Half of the cosmetology arts and sciences licensees shall renew for the period of April 1 of an odd-numbered year to March 31 of the next odd-numbered year. This group of cosmetology arts and sciences licensees shall be designated as "B's."

*c.* Licensees will be notified at time of renewal whether they are licensed as an "A" or "B."

**64.1(3)** Hours of continuing education credit may be obtained by attending and participating in a continuing education activity, either previously accredited by the board or which otherwise meets the requirements herein and is approved by the board pursuant to 645—64.7(272C).

**64.1(4)** It is the responsibility of each licensee to finance the costs of continuing education.

**64.1(5)** Those persons newly licensed during the license renewal period shall not be required to complete continuing education as a prerequisite for their renewal license.

**64.1(6)** Licensees currently licensed in Iowa but practicing in another state may comply with Iowa continuing education requirements for license renewal by meeting the continuing education requirements of the licensee's place of practice. Those licensees living and practicing in a state which has no continuing education requirement for renewal of license shall not be required to meet Iowa's continuing education requirement but shall pay all renewal fees when due.

**64.1(7)** Lapsed licensees residing in another state seeking reinstatement of an Iowa license shall be required to comply with 645—60.13(272C).

**645—64.2(272C) Report of licensee.** Licensees shall submit a completed report form which documents the completion of continuing education requirements.

**645—64.3(272C) Licensed instructors.** Rescinded IAB 3/10/99, effective 4/14/99.

**645—64.4(272C) Physical and mental disability or illness.** The board may, in individual cases involving physical or mental disability or illness, grant waivers of the minimum education requirements or extension of time within which to fulfill the same or make the required reports. No waiver or extension of time shall be granted unless written application thereof shall be made on forms provided by the board and signed by the licensee and a physician licensed by the board of medical examiners. Waivers of the minimum educational requirements may be granted by the board for a period of time not to exceed one calendar year. In the event that physical or mental disability or illness upon which a waiver has been granted continues beyond the period of the waiver, the licensee must apply for an extension of the waiver. The board may, as a condition of any waiver granted, require the applicant to make up a certain portion or all of the minimum educational requirements waived by such methods as may be prescribed by the board.

**645—64.5(272C) Exemptions for inactive licensees.** A licensee who is not engaged in the practice in the state of Iowa residing in or without the state of Iowa may be granted a waiver of compliance and obtain a certificate of exemption upon written application to the board. The application shall contain a statement that the applicant will not engage in the practice in the state of Iowa without first complying with all regulations governing reinstatement after exemption. The application for a certificate of exemption shall be submitted upon the form provided by the board. A licensee must be currently licensed to apply for exempt status.

**645—64.6(272C) Standards for approval.** Continuing education is that board-approved education which is obtained by a licensee in order to maintain, improve, or expand skills and knowledge obtained prior to initial licensure or to develop new and relevant skills and knowledge. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if it:

1. Constitutes an organized program of learning (including a workshop or symposium) which contributes directly to the professional competency of the licensee; and

2. Pertains to common subject matters which integrally relate to the practice of the professions; and

3. Is conducted by individuals who have special education, training and experience by reason of which said individuals should be considered experts concerning the subject matter of the program, and is accompanied by a paper, manual or outline which substantively pertains to the subject matter of the program and reflects program schedule, goals and objectives. The board may request a curriculum vitae of presenters.

4. The instruction of product knowledge, methods and systems is allowed; however, no direct selling of products is allowed as part of a continuing education offering.

5. Fulfills stated program goals and objectives or both.

6. Provides proof of attendance to licensees in attendance including:

- Date, place, course title, presenter(s).
- Number of program contact hours. (One contact hour equals 50 minutes of continuing education credit.)
- Identification of practice specialty.
- Official signature of program sponsor.

**64.6(1)** *Accreditation of sponsors.* An applicant not previously accredited by the board, which desires accreditation as a sponsor of courses, programs, and other continuing education activities, including individually designed programs, shall apply for accreditation to the board stating its education history, subjects offered, total hours of instruction presented, and the names and qualifications of instructors. Activities of such an approved sponsor which are relevant to cosmetology arts and sciences shall be deemed automatically approved for continuing education credit. By January 31 of each year, all accredited sponsors shall report to the board in writing the education programs conducted during the preceding calendar year on a form approved by the board.

The board may at any time reevaluate an accredited sponsor. If after reevaluation the board finds there is basis for consideration or revocation of the accreditation of an accredited sponsor, the board shall give notice by ordinary mail to that sponsor of hearing on possible revocation at least 30 days prior to the hearing. The decision of the board after the hearing shall be final.

*a.* All approved, accredited sponsors shall issue a certificate of attendance to each licensee who attends a continuing education activity. The certificate shall include sponsor name and number; date of program; name of participant; total number of clock hours excluding introduction, breaks, and meals; program title and presenter; program site; practice specialty; and whether the program is approved for cosmetology.

*b.* All approved, accredited sponsors shall maintain a copy of the continuing education activity, a list of attendees, attendees' license numbers, and number of continuing education clock hours awarded for a minimum of three years from the date of the continuing education activity.

**64.6(2)** *Prior to approval of activities.* An applicant other than an accredited sponsor, which desires prior approval of a course, program or other continuing education activity, shall apply for approval to the board at least 60 days in advance of the commencement of the activity on a form provided by the board. The board shall approve or deny such application in writing. The application shall state the dates, subjects offered, total hours of instruction, names and qualifications of speakers and other pertinent information.

**64.6(3)** *Review of programs.* The board may monitor or review any continuing education program already approved by the board and, upon evidence of significant variation in the program presented from the program approved, may disapprove all or any part of the approved hours granted by the program.

**64.6(4)** *Postapproval of activities.* A licensee seeking credit for attendance and participation in an educational activity which was not otherwise approved shall submit to the board, within 30 days after completion of activity, a request for credit, including a brief résumé of the activity, its dates, subjects, instructors, and their qualifications and the number of credit hours requested therefor. Within 60 days after the receipt of such application, the board shall advise the licensee in writing by ordinary mail whether the activity is approved and the number of hours allowed therefor. A licensee not complying with requirements of this subrule may be denied credit for such activity.

**64.6(5)** *Report of licensee.* The licensee shall maintain a record of verification of attendance for at least four years from date of completion of the continuing education program. Each licensee shall file, if requested, a certificate of attendance form signed by the educational institution or organization sponsoring the continuing education. The report shall be sent to the Board of Cosmetology Arts and Sciences Examiners, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**64.6(6)** *Audit of continuing education reports.*

*a.* After each educational biennium the board will audit a percentage of the continuing education reports at random before the renewal licenses are issued to those being audited.

*b.* The licensee must make the following information available to the board for auditing purposes:

(1) Date, place, course title, schedule, presenter(s).

(2) Number of contact hours for program attended.

(3) Official signature of sponsor indicating successful completion of course.

*c.* For auditing purposes the licensee must retain the above information for four years.

**64.6(7)** *Hearings regarding continuing education.* In the event of denial, in whole or part, of any application for approval of a continuing education program or credit for a continuing education activity, the applicant or licensee shall have the right to request a hearing. The request must be sent within 20 days after receipt of the notification of denial. The hearing shall be held within 90 days after receipt of the request for hearing. The hearing shall be conducted by the board. The final decision shall be rendered by the board.

**645—64.7(272C) Approval of sponsors.** An educational institution, e.g., cosmetology school of arts and sciences, merged area school, university or professional society not previously approved by the board which desires approval as a sponsor of courses, programs, or other continuing education activities shall apply for approval to the board stating its education history relating to the practices under 645—Chapter 60 for the preceding two years, including approximate dates, subjects offered, total hours of instruction presented, and the names and qualifications of instructors.

**64.7(1)** *Prior notice.* All accredited sponsors shall submit to the board at least 30 days in advance of the program the dates, locations, and instructors for all intended educational programs. All promotional material shall prominently display the approved sponsor's name. Program credit may be denied if the foregoing is not complied with fully.

EXCEPTION: Approved cosmetology school sponsors may assist licensees to reinstate by providing an individual with continuing education classes.

**64.7(2)** Reserved.

**645—64.8(272C) Attendance record.** Rescinded IAB 12/4/96, effective 1/8/97.

These rules are intended to implement Iowa Code sections 272C.1, 272C.2 and 272C.3.

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CHAPTER 15
CORRECTIONAL FACILITY
PHARMACY LICENSES

15.1(124,126,155A) General requirements
15.2(124,126,155A) Sanitation
15.3(124,126,155A) Reference library
15.4(124,126,155A) Prescription department equipment
15.5(124,126,155A) Security
15.6(124,126,155A) Procurement and storage of drugs
15.7(124,126,155A) Records
15.8(124,126,155A) Drug distribution and dispensing
15.9(124,126,155A) Pharmacist in charge
15.10(124,126,155A) Policies and procedures
15.11(124,126,155A) Orders for medication received in the absence of a pharmacist
15.12(155A) Training and utilization of pharmacy technicians

CHAPTER 16
NUCLEAR PHARMACY

16.1(155A) Purpose and scope
16.2(155A) Definitions
16.3(155A) General requirements for pharmacies providing radiopharmaceutical services
16.4(155A) General requirements for nuclear pharmacists to obtain a nuclear pharmacy license
16.5(155A) Library
16.6(155A) Minimum equipment requirements
16.7(155A) Training and utilization of pharmacy technicians

CHAPTER 17
WHOLESALE DRUG LICENSES

17.1(155A) Definitions
17.2(155A) Wholesale drug distributor licensing requirements
17.3(155A) Minimum required information for licensure
17.4(155A) Minimum qualifications
17.5(155A) Personnel
17.6(155A) Facilities
17.7(155A) Security
17.8(155A) Storage
17.9(155A) Examination of materials
17.10(155A) Returned, damaged, and outdated prescription drugs
17.11(155A) Record keeping
17.12(155A) Written policies and procedures
17.13(155A) Responsible persons
17.14(155A) Compliance with federal, state, and local laws
17.15(155A) Salvaging and reprocessing
17.16(155A) Discipline

CHAPTER 18
ANABOLIC STEROIDS

18.1(126) Definition of anabolic steroid
18.2(126) Exception to definition

CHAPTER 19
NONRESIDENT PHARMACY LICENSES

19.1(155A) Definitions
19.2(155A) Application and license requirements
19.3(155A) Discipline
19.4(155A) Training and utilization of pharmacy technicians
19.5(135C,155A) Personnel histories

CHAPTER 20
PHARMACY COMPOUNDING
PRACTICES

20.1(124,126,155A) Purpose and scope
20.2(124,126,155A) Definitions
20.3(124,126,155A) General requirements
20.4(126,155A) Organization and personnel
20.5(126,155A) Drug compounding facilities
20.6(126,155A) Sterile products
20.7(126,155A) Special precaution products
20.8(126,155A) Equipment
20.9(126,155A) Control of components and drug product containers and closures
20.10(124,126,155A) Drug compounding controls
20.11(126) Bulk compounding
20.12(124,126,155A) Records and reports

CHAPTER 21
CONFIDENTIAL AND ELECTRONIC DATA IN PHARMACY PRACTICE

21.1(124,155A) Definitions
21.2(124,155A) Confidentiality and security of patient records and prescription drug orders
21.3(124,155A) Manner of issuance of a prescription drug order
21.4(124,155A) Computer-to-computer transmission of a prescription
21.5(124,155A) Facsimile transmission of a prescription
21.6(124,155A) Prescription drug orders for Schedule II controlled substances
21.7(124,155A) Prescription drug orders for Schedule II controlled substances—emergency situations
21.8(124,155A) Facsimile transmission of a prescription for Schedule II narcotic substances—parenteral
21.9(124,155A) Facsimile transmission of Schedule II controlled substances—long-term care facility patients
21.10(124,155A) Facsimile transmission of Schedule II controlled substances—hospice patients
21.11(124,155A) Automated data processing system—controlled substances refill information

CHAPTER 22
PHARMACY TECHNICIANS

22.1(155A) Definitions
22.2(155A) Purpose of registration
22.3(155A) Denial of registration
22.4(155A) Registration required
22.5(155A) Registration application form
22.6(155A) Registration renewal
22.7(155A) Registration fee
22.8(155A) Late application
22.9(155A) Registration certificates
22.10(155A) Notifications to the board
22.11(155A) Identification of pharmacy technician
22.12(155A) Tasks a pharmacy technician shall not perform
22.13(155A) Delegation of technical functions
22.14(155A) Technical functions
22.15(155A) New prescription drug orders or medication orders
22.16(155A) Training and utilization of pharmacy technicians
22.17(155A) Certification of pharmacy technicians
22.18(155A) Discipline of pharmacy technicians
22.19(155A) Responsibility of supervising pharmacist
22.20(155A) Persons exempt from registration
22.21(147,155A) Unethical conduct or practice

CHAPTERS 23 and 24
Reserved

CHAPTER 25
CHILD SUPPORT NONCOMPLIANCE

25.1(252J) Definitions
25.2(252J) Issuance or renewal of license—denial
25.3(252J) Suspension or revocation of a license
25.4(17A,22,252J) Share information

CHAPTER 26
PETITIONS FOR RULE MAKING
(Uniform Rules)

26.1(17A) Petition for rule making
26.3(17A) Inquiries

CHAPTER 27
DECLARATORY RULINGS
(Uniform Rules)

27.1(17A) Petition for declaratory ruling
27.3(17A) Inquiries

CHAPTER 28
AGENCY PROCEDURE
FOR RULE MAKING
(Uniform Rules)

28.3(17A) Public rule-making docket
28.4(17A) Notice of proposed rule making
28.5(17A) Public participation
28.6(17A) Regulatory flexibility analysis
28.10(17A) Exemptions from rule-making procedures
28.11(17A) Concise statement of reasons
28.13(17A) Agency rule-making record

CHAPTER 29
SALES OF GOODS AND SERVICES

29.1(68B) Selling of goods or services by members of the board
29.2(68B) Conditions of consent for board members
29.3(68B) Authorized sales
29.4(68B) Application for consent
29.5(68B) Limitation of consent

CHAPTER 30
IMPAIRED PHARMACY PROFESSIONAL
AND TECHNICIAN RECOVERY
PROGRAM

30.1(155A) Definitions
30.2(155A) Purpose, function, and responsibilities
30.3(155A) Program committee and personnel; confidentiality; liability
30.4(155A) Identification and referral of impaired pharmacy professionals and pharmacy technicians
30.5(155A) Recovery contract requirements
30.6(155A) Program provider contract
30.7(155A) Disclosure of information
30.8(155A) Program funds

CHAPTER 31
STUDENT LOAN DEFAULT OR
NONCOMPLIANCE WITH AGREEMENT
FOR PAYMENT OF OBLIGATION

31.1(261) Definitions
31.2(261) Issuance or renewal of a license—denial
31.3(261) Suspension or revocation of a license
31.4(17A,22,261) Share information

# CHAPTER 6
# GENERAL PHARMACY LICENSES

[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 2]

**657—6.1(155A) Applicability.** A general pharmacy is a location where a pharmacist practices in accordance with pharmacy laws. This chapter does not apply to hospital pharmacy licenses issued pursuant to 657—Chapter 7.

**657—6.2(155A) Personnel.**

6.2(1) *Pharmacist in charge.* Each pharmacy shall have one pharmacist in charge who is responsible for, at a minimum, the following:

*a.* Ensuring that a pharmacist performs prospective drug review as specified in rule 657—8.19(155A);

*b.* Ensuring that a pharmacist provides patient counseling as specified in rule 657—8.20(155A);

*c.* Dispensing drugs to patients, including any packaging, preparation, compounding, and labeling of the drug which is performed by pharmacy personnel;

*d.* Delivering drugs to the patient or the patient's agent;

*e.* Ensuring that patient medication records are maintained as specified in rule 657—8.18(155A);

*f.* Training pharmacy technicians and supportive personnel;

*g.* Establishing policies for procurement of prescription drugs and devices and other products dispensed from the pharmacy;

*h.* Disposing of and distributing drugs from the pharmacy;

*i.* Maintaining records of all transactions of the pharmacy necessary to maintain accurate control over and accountability for all drugs as required by applicable state and federal laws, rules, and regulations;

*j.* Establishing and maintaining effective controls against the theft or diversion of prescription drugs and records for such drugs;

*k.* Legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, or regulations governing the practice of pharmacy.

6.2(2) *Pharmacists.* The pharmacist in charge shall be assisted by a sufficient number of additional licensed pharmacists as may be required to operate the pharmacy competently, safely, legally, and adequately to meet the needs of the patients of the pharmacy.

*a.* Pharmacists shall assist the pharmacist in charge in meeting the responsibilities identified in subrule 6.2(1).

*b.* Pharmacists are solely responsible for the direct supervision of pharmacy technicians and for designating and delegating duties pursuant to 657—Chapter 22 and rule 657—8.1(155A).

*c.* All pharmacists shall be responsible for complying with state and federal laws or rules governing the practice of pharmacy.

6.2(3) *Other personnel.*

*a.* Pharmacist-interns, pursuant to the requirements and limitations contained in 657—Chapter 4, shall assist the pharmacist in charge in meeting the responsibilities identified in subrule 6.2(1).

*b.* Pharmacy technicians and other support personnel, pursuant to the requirements and limitations contained in 657—Chapter 22, shall assist the pharmacist in charge in meeting the responsibilities identified in subrule 6.2(1).

6.2(4) *Personnel histories.* Pursuant to the requirements of Iowa Code section 135C.33, the provisions of this subrule shall apply to any pharmacy employing any person to provide patient care services in a patient's home. For the purposes of this subrule, "employed by the pharmacy" shall include any individual who is paid, either by the pharmacy or by any other entity such as a corporate entity, a temporary agency, or an independent contractor, to provide treatment or services to any patient in the patient's home. Specifically excluded from the requirements of this subrule are individuals such as delivery persons or couriers who do not enter the patient's home for the purpose of instructing the patient or the patient's caregiver in the use or maintenance of the equipment, device, or medication being delivered, or who do not enter the patient's home for the purpose of setting up or servicing the equipment, device, or medication used to treat the patient in the patient's home.

*a.* The pharmacy shall ask the following question of each person seeking employment in a position which will provide in-home services: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?" The applicant shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The applicant shall indicate, by signed acknowledgment, that the applicant has been informed that such record checks will be conducted.

*b.* Prior to the employment of any person to provide in-home services, the pharmacy shall submit a form specified by the department of public safety to the department of public safety and receive the results of a criminal history check and dependent adult abuse record check. The pharmacy may submit a form specified by the department of human services to the department of human services to request a child abuse history check.

*c.* A person who has a criminal record, founded dependent adult abuse report, or founded child abuse report shall not be employed by a pharmacy to provide in-home services unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse does not merit prohibition from such employment.

*d.* The pharmacy shall keep copies of all record checks and evaluations.

**657—6.3(155A) Reference library.** References may be printed or computer-accessed. A reference library shall be maintained which includes, as a minimum, one reference from each of the following:

1. Current Iowa pharmacy laws, rules, and regulations.
2. A patient information reference, updated at least annually, such as:
- United States Pharmacopeia Dispensing Information, Volume II (Advice to the Patient);
- Facts and Comparisons Patient Drug Facts; or
- Leaflets which provide patient information in compliance with rule 657—8.20(155A).
3. A current reference on drug interactions, such as:
- Phillip D. Hansten's Drug Interactions; or
- Facts and Comparisons Drug Interactions.
4. A general information reference, updated at least annually, such as:
- Facts and Comparisons with current supplements;
- United States Pharmacopeia Dispensing Information, Volume I (Drug Information for the Healthcare Provider); or
- American Hospital Formulary Service with current supplements.
5. A current drug equivalency reference, including supplements, such as:
- Approved Drugs Products With Therapeutic Equivalence Evaluations (FDA Orange Book);
- ABC - Approved Bioequivalency Codes; or
- USP DI, Volume III.
6. Basic antidote information or the telephone number of a poison control center.
7. Additional references as may be necessary for the pharmacist to adequately meet the needs of the patients served.

**657—6.4(155A) Prescription department equipment.** The prescription department shall have, as a minimum, the following:

1. Measuring devices such as syringes or graduates capable of measuring 1 ml. to 250 ml.;
2. Suitable refrigeration unit. The temperature of the refrigerator shall be maintained within a range compatible with the proper storage of drugs requiring refrigeration;
3. Other equipment as necessary for the particular practice of pharmacy.

**657—6.5(155A) Environment.**

**6.5(1)** *Space, equipment, and supplies.* There shall be adequate space, equipment, and supplies for the professional and administrative functions of the pharmacy.

**6.5(2)** *Clean and orderly.* The pharmacy shall be arranged in an orderly fashion and kept clean. All required equipment shall be in good operating condition and maintained in a sanitary manner.

**6.5(3)** *Sink.* A pharmacy shall have a sink with hot and cold running water within the prescription department, available to all pharmacy personnel, and maintained in a sanitary condition.

**6.5(4)** *Counseling area.* A pharmacy shall contain an area which is suitable for confidential patient counseling. Such area shall:

*a.* Be easily accessible to both patients and pharmacists and not allow patient access to prescription drugs;

*b.* Be designed to maintain the confidentiality and privacy of the pharmacist/patient communication.

**6.5(5)** *Lighting and ventilation.* The pharmacy shall be properly lighted and ventilated.

**6.5(6)** *Temperature.* The temperature of the pharmacy shall be maintained within a range compatible with the proper storage of drugs.

**657—6.6(155A) Security.** Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of prescription drugs, and records for such drugs.

**6.6(1)** The prescription department shall be locked by key or combination so as to prevent access when a pharmacist is not on site except as provided in subrule 6.6(2).

**6.6(2)** In the temporary absence of the pharmacist, only the pharmacist in charge may designate persons who may be present in the prescription department to perform technical and nontechnical functions designated by the pharmacist in charge. Activities identified in subrule 6.6(3) may not be performed during such temporary absence of the pharmacist. A temporary absence is an absence of short duration not to exceed two hours.

**6.6(3)** Activities which shall not be designated and shall not be performed during the temporary absence of the pharmacist include:

*a.* Dispensing or distributing any prescription medications to patients or others.

*b.* Providing the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order.

*c.* Conducting prospective drug use review or evaluating a patient's medication record for purposes identified in rule 657—8.19(155A).

*d.* Providing patient counseling, consultation, or patient-specific drug information.

*e.* Making decisions that require a pharmacist's professional judgment such as interpreting or applying information.

*f.* Prescription transfers to or from other pharmacies.

**657—6.7(155A) Procurement and storage of drugs.** The pharmacist in charge shall have the responsibility for the procurement and storage of drugs.

**6.7(1)** Prescription drugs and devices and nonprescription Schedule V controlled substances shall be stored within the prescription department or a secure storage area.

**6.7(2)** All drugs shall be stored at the proper temperature, as defined by the following terms:

*a.* Controlled room temperature — temperature maintained thermostatically between 15 degrees and 30 degrees Celsius (59 degrees and 86 degrees Fahrenheit);

*b.* Cool — temperature between 8 degrees and 15 degrees Celsius (46 degrees and 59 degrees Fahrenheit) which may, alternatively, be stored in a refrigerator unless otherwise specified on the labeling;

*c.* Refrigerate — temperature maintained thermostatically between 2 degrees and 8 degrees Celsius (36 degrees and 46 degrees Fahrenheit); and

*d.* Freeze — temperature maintained thermostatically between -20 degrees and -10 degrees Celsius (-4 degrees and 14 degrees Fahrenheit).

**6.7(3)** Out-of-date drugs or devices.

*a.* Any drug or device bearing an expiration date shall not be dispensed beyond the expiration date of the drug or device.

*b.* Outdated drugs or devices shall be removed from dispensing stock and shall be quarantined until such drugs or devices are disposed of properly.

**657—6.8(155A) Records.** Every inventory or other record required to be kept under Iowa Code chapters 124 and 155A or 657—Chapter 6 shall be kept at the licensed location of the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of the inventory or record except as otherwise required in this rule. Controlled substance records shall be maintained in a readily retrievable manner in accordance with federal requirements. Those requirements, in summary, are as follows:

**6.8(1)** Controlled substance records shall be maintained in a manner to establish receipt and distribution of all controlled substances;

**6.8(2)** Records of controlled substances in Schedule II shall be maintained separately from records of controlled substances in Schedules III, IV, and V and all other records;

**6.8(3)** A Schedule V nonprescription registry book shall be maintained in accordance with 657—subrule 10.13(13).

**6.8(4)** Invoices involving the distribution of Schedule III, IV, or V controlled substances to another pharmacy or practitioner must show the actual date of distribution; the name, strength, and quantity of controlled substances distributed; the name, address, and DEA registration number of the distributing pharmacy and of the practitioner or pharmacy receiving the controlled substances;

**6.8(5)** Copy 1 of DEA Order Form 222, furnished by the pharmacy or practitioner to whom Schedule II controlled substances are distributed, shall be maintained by the distributing pharmacy and shall show the quantity of controlled substances distributed and the actual date of distribution;

**6.8(6)** Copy 3 of DEA Order Form 222 shall be properly dated, initialed, and filed and shall include all copies of each unaccepted or defective order form and any attached statements or other documents;

**6.8(7)** If controlled substances, prescription drugs, or nonprescription drug items are listed on the same record, the controlled substances shall be asterisked, red-lined, or in some other manner readily identifiable from all other items appearing on the records;

**6.8(8)** Suppliers' invoices of prescription drugs and controlled substances shall clearly record the actual date of receipt by the pharmacist or other responsible individual;

**6.8(9)** Suppliers' credit memos for controlled substances and prescription drugs shall be maintained;

**6.8(10)** A biennial inventory of controlled substances shall be maintained for a minimum of four years from the date of the inventory;

**6.8(11)** Reports of theft or significant loss of controlled substances shall be maintained;

**6.8(12)** Reports of surrender or destruction of controlled substances shall be maintained;

**6.8(13)** Records, except when specifically required to be maintained in original or hard-copy form, may be maintained in an alternative data retention system, such as a data processing system or direct imaging system provided:

*a.* The records maintained in the alternative system contain all of the information required on the manual record; and

*b.* The data processing system is capable of producing a hard copy of the record upon the request of the board, its representative, or other authorized local, state, or federal law enforcement or regulatory agencies.

**657—6.9(126) Return of drugs and appliances.** For the protection of the public health and safety, prescription drugs shall not be returned, exchanged, or resold unless, in the professional judgment of the pharmacist, the integrity of the prescription drug has not in any way been compromised. Prescription drugs may, however, be returned and reused as authorized in 657—subrule 8.9(6). No items of personal contact nature which have been removed from the original package or container after sale shall be accepted for return, exchanged, or resold by any pharmacist.

**657—6.10(155A) Training and utilization of pharmacy technicians.** General pharmacies utilizing pharmacy technicians shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians. Pharmacy policies shall specify the frequency of review. Technician training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of technician training shall be available for inspection by the board or an agent of the board.

These rules are intended to implement Iowa Code sections 124.303, 124.306 to 124.308, 126.10, 155A.13, 155A.31, 155A.32, and 155A.35.

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◊Two ARCs

*b.* Some small facilities may not require, or be able to obtain, the services of a full-time pharmacist. However, it should be noted that the concepts, principles, and recommendations contained in this rule apply to all hospitals, regardless of size or type. Thus, the part-time pharmacist in charge has the same basic obligations and responsibilities as the full-time pharmacist in charge in the larger institution.

**7.6(6)** *Personnel histories.* Pursuant to the requirements of Iowa Code section 135C.33, the provisions of this subrule shall apply to any pharmacy employing any person to provide patient care services in a patient's home. For the purposes of this subrule, "employed by the pharmacy" shall include any individual who is paid, either by the pharmacy or by any other entity such as a corporate entity, a temporary agency, or an independent contractor, to provide treatment or services to any patient in the patient's home. Specifically excluded from the requirements of this subrule are individuals such as delivery persons or couriers who do not enter the patient's home for the purpose of instructing the patient or the patient's caregiver in the use or maintenance of the equipment, device, or medication being delivered, or who do not enter the patient's home for the purpose of setting up or servicing the equipment, device, or medication used to treat the patient in the patient's home.

*a.* The pharmacy shall ask the following question of each person seeking employment in a position which will provide in-home services: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?" The applicant shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The applicant shall indicate, by signed acknowledgment, that the applicant has been informed that such record checks will be conducted.

*b.* Prior to the employment of any person to provide in-home services, the pharmacy shall submit a form specified by the department of public safety to the department of public safety and receive the results of a criminal history check and dependent adult abuse record check. The pharmacy may submit a form specified by the department of human services to the department of human services to request a child abuse history check.

*c.* A person who has a criminal record, founded dependent adult abuse report, or founded child abuse report shall not be employed by a pharmacy to provide in-home services unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse does not merit prohibition from such employment.

*d.* The pharmacy shall keep copies of all record checks and evaluations.

**657—7.7(155A) Training and utilization of pharmacy technicians.** Hospital pharmacies utilizing pharmacy technicians shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians. Pharmacy policies shall specify the frequency of review. Technician training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of technician training shall be available for inspection by the board or an agent of the board.

**657—7.8(124,126,155A) Drug distribution and control.** The pharmacist in charge shall be responsible for the procurement, distribution, and control of all drugs used within the institution. This responsibility extends to drugs and related services provided to ambulatory patients. Policies and procedures governing these functions shall be developed by the pharmacist in charge with input from other involved hospital staff such as physicians and nurses, from committees such as the pharmacy and therapeutics committee or its equivalent, and from any related patient care committee. In doing so, it is essential that the pharmacist in charge or designee routinely be available to or on all patient care areas, establish rapport with the personnel, and become familiar with and contribute to medical and nursing procedures relating to drugs.

7.8(1) *Drug formulary.* The pharmacist in charge shall maintain a current formulary of drug products approved for use in the institution and shall be responsible for specifications for those drug products and for selecting their source of supply.

7.8(2) *Investigational drugs.* The pharmacy shall be responsible for establishing policies and procedures controlling the use of investigational drugs if used in the institution.

*a.* A pharmacist shall be a member of the institutional review board.

*b.* The pharmacy shall be responsible, in cooperation with the principal investigator, for providing information about investigational drugs used in the institution.

*c.* If applicable, the pharmacist shall conduct, participate in, and support medical and pharmaceutical research appropriate to the goals, objectives, and resources of the pharmacy and the institution.

7.8(3) *Disaster services.* There shall be a procedure for providing drugs and pharmaceutical services in the event of a disaster.

7.8(4) *Samples.* The use of drug samples within the institution shall be eliminated to the extent possible. However, if the use of drug samples is permitted, they shall be controlled and distributed through the pharmacy or through a process developed in cooperation with the pharmacy and the institution's appropriate patient care committee, subject to oversight by the pharmacy.

7.8(5) *Medication orders.* The pharmacist shall review an authorized prescriber's original order, or a direct copy, prior to dispensing any drug except for emergency use. There shall be no transcribing of medication orders by nursing or clerical staffs except for their own records. Hospitalwide and pharmacy stand-alone computer systems shall be secure against unauthorized entry. All orders shall use only standard approved abbreviations and chemical symbols. All systems shall provide for review and verification of the prescriber's original order before the drug is dispensed.

7.8(6) *Drug distribution.* The pharmacist shall institute the control procedures needed to ensure that patients receive the correct drugs at the proper times.

*a.* In the interest of patient safety, all drugs dispensed by the pharmacist for administration to patients shall be in single unit packages if practicable. Thus, the need for nurses to manipulate drugs prior to their administration should be minimized.

*b.* Where applicable, pharmacy personnel shall prepare all sterile products including chemotherapy injections, continuous and intermittent intravenous preparations, and irrigation solutions, except in emergencies.

*c.* When feasible, the pharmacist shall prepare those drug formulations, strengths, dosage forms, and packages that are not available commercially but which are useful in the care of patients. Adequate quality assurance procedures shall be developed for these operations.

**7.8(7)** *Hazardous drugs and chemicals.* The pharmacist, in cooperation with other hospital staff, shall establish policies and procedures for handling drugs and chemicals that are known occupational hazards. The procedures shall maintain the integrity of the drug or chemical and protect the hospital personnel.

**7.8(8)** *Emergency drug supplies and floor stock.* Supplies of drugs for use in medical emergencies shall be immediately available at each nursing unit or service area as specified in policies and procedures. Stocks of drugs shall be as limited as possible. Authorized stocks shall be periodically reviewed in a multidisciplinary manner. All drug storage areas within the hospital shall be routinely inspected to ensure that no outdated or unusable items are present and that all stock items are properly labeled and stored.

**7.8(9)** *Product recall.* There shall be a system for removing from use any drugs subjected to a product recall.

**7.8(10)** *Stop order.* A written stop-order policy or other system shall be established to ensure that drug orders are not inappropriately continued.

**7.8(11)** *Drugs brought into the institution.* Policies and procedures shall be established for the identification of medications brought into the institution for use by patients.

**657—7.9(124,155A) Drug information.** The pharmacy is responsible for providing the institution's staff and patients with accurate, comprehensive information about drugs and their use and shall serve as its center for drug information.

**7.9(1)** *Staff education.* The pharmacist shall keep the institution's staff well-informed about the drugs used in the institution and their various dosage forms and packagings.

**7.9(2)** *Patient education.* The pharmacist shall help ensure that all patients are given adequate information about the drugs they receive. This is particularly important for ambulatory, home care, and discharge patients. These patient education activities shall be coordinated with the nursing and medical staffs and patient education department, if any.

**657—7.10(124,155A) Ensuring rational drug therapy.** An important aspect of pharmaceutical services is that of maximizing rational drug use. In this regard, the pharmacist, in concert with the medical staff, shall develop policies and procedures for ensuring the quality of drug therapy.

**7.10(1)** *Patient profile.* Sufficient patient information shall be collected, maintained, and reviewed by the pharmacist to ensure meaningful and effective participation in patient care. This requires that a medication profile be maintained for all inpatients and for those ambulatory patients routinely receiving care at the hospital. A pharmacist-conducted medication history from patients may be useful in this regard.

*a.* Appropriate clinical information about patients shall be available and accessible to the pharmacist for use in daily practice activities.

*b.* The pharmacist shall review each patient's drug regimen on a concurrent basis and directly communicate any suggested changes to the prescriber.

**7.10(2)** *Adverse drug events.* The pharmacist, in cooperation with the appropriate patient care committee, shall develop a mechanism for the reporting and review, by the committee or other appropriate medical group, of adverse drug events.

**657—7.11** Reserved.

**657—7.12(124,126,155A) Drugs dispensed to patients as a result of an emergency room visit.** In those facilities with 24-hour pharmacy services, any drugs dispensed to an outpatient, including emergency department patients, may be dispensed only by a pharmacist or practitioner. In those facilities without 24-hour pharmacy services, or those facilities without outpatient pharmacy services, or when outpatient pharmacy services are not available, the following procedures shall be observed in dispensing drugs:

**7.12(1)** *Patients examined in emergency room.* Drugs may be dispensed only to patients who have been examined in the emergency room.

**7.12(2)** *Accountability.* Drugs may be dispensed only in accordance with the system of control and accountability for drugs administered or dispensed from the emergency room.

*a.* Such system shall be developed and supervised by the pharmacist in charge and the facility's emergency department committee, or a similar group or person responsible for policy in that department.

*b.* The system shall consist of drugs of the nature and type to meet the immediate needs of emergency room patients.

*c.* Controlled substances maintained in the emergency room are kept for use by, or at the direction of, prescribers in the emergency room. In order to receive controlled drugs, a patient must be examined by a prescriber in the emergency room where the need for a controlled substance must be determined. It is not permissible under state and federal requirements for a prescriber to see a patient outside of the emergency room setting, or talk to the patient on the telephone, and then proceed to call the emergency room and order the administration of a stocked controlled substance upon the patient's arrival at the emergency room.

*d.* The pharmacist in charge is responsible for maintaining accurate records of dispensing of drugs from the emergency room.

**7.12(3)** *Prepackaging.* Drugs dispensed in greater than a 24-hour supply may be dispensed only in prepackaged quantities not to exceed a 72-hour supply or the minimum prepackaged quantity in suitable containers and appropriately labeled as required in subrule 7.12(4), including necessary auxiliary labels.

**7.12(4)** *Labeling.* At the time of delivery of the medication, the practitioner shall appropriately complete the label, such that the dispensing container bears a label with at least the following information:

1. Name and address of the hospital;
2. Date dispensed;
3. Name of prescriber;
4. Name of patient;
5. Directions for use;
6. Name and strength of drug.

**7.12(5)** *Delivery of medication to patient.* The practitioner, or a licensed nurse under the supervision of the practitioner, shall give the appropriately labeled, prepackaged medication to the patient and explain the correct use of the drug.

**7.12(6)** *Verification of dispensing record.* Rescinded IAB 1/1/97, effective 2/5/97.

**657—7.13(124,155A) Records.** Every inventory or other record required to be kept under this chapter or under Iowa Code chapters 124 and 155A shall be kept by the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record except as otherwise required in this rule.

**7.13(1)** *Medication order information.* Each original medication order contained in inpatient records shall bear the following information:

*a.* Patient name and identification number;

*b.* Drug name, strength, and dosage form;

*c.* Directions for use;

*d.* Date;

*e.* Practitioner's signature or that of the practitioner's authorized agent. Any order signed by an authorized agent shall be cosigned by the practitioner within 72 hours.

**7.13(2)** *Medication order maintained.* The original medication order shall be maintained with the medication administration record in the medical records of the patient following discharge.

**7.13(3)** *Documentation of drug administration.* Each dose of medication administered shall be properly recorded in the patient's medical record.

**7.13(4)** *Controlled substances records.* Controlled substances records shall be maintained as follows:

*a.* All records for controlled substances shall be maintained in a readily retrievable manner.

*b.* Controlled substances records shall be maintained in a manner to establish receipt and distribution of all controlled substances.

*c.* Schedule II controlled substances records shall be maintained separately from records of controlled substances in Schedules III, IV, and V, and all other records.

*d.* Distribution records for non-patient-specific, floor-stocked controlled substances shall bear the following information:

(1) Patient's name;

(2) Prescriber who ordered drug;

(3) Name of drug, dosage form, and strength;

(4) Time and date of administration to patient and quantity administered;

(5) Signature or unique electronic signature of individual administering controlled substance;

(6) Returns to the pharmacy;

(7) Waste, which is required to be witnessed and cosigned by another licensed health professional.

**7.13(5)** *Other pharmacy records.* Other records to be maintained by a pharmacy include:

*a.* Copy 3 of DEA order Form 222 which has been properly dated, initialed, and filed, and all copies of each unaccepted or defective order form and any attached statements or other documents.

*b.* Supplier's invoices of prescription drugs and controlled substances upon which is clearly recorded the actual date of receipt of the controlled substances by the pharmacist or other responsible individual.

*c.* Suppliers' credit memos for controlled substances and prescription drugs.

*d.* Biennial inventory of controlled substances required by the Drug Enforcement Administration that shall be maintained for a minimum of four years from the date of the inventory.

*e.* Drug Enforcement Administration reports of theft or significant loss of controlled substances.

*f.* Reports of surrender, destruction, or disposition of controlled substances.

*g.* Schedule V nonprescription register book, if applicable.

*h.* If a pharmacy distributes controlled substances to another pharmacy or a practitioner, the following records shall be maintained by the distributing pharmacy:

(1) If for Schedule III, IV, or V controlled substances, invoices showing the actual date of distribution; the name, strength, and quantity of controlled substances distributed; the name, address, and DEA registration number of the distributing pharmacy; and the name, address, and DEA registration number of the pharmacy or practitioner to whom the controlled substances are distributed.

(2) If for Schedule I or II controlled substances, copy 1 of DEA order Form 222, furnished by the pharmacy or practitioner to whom the controlled substances are distributed, showing the quantity of controlled substances distributed and the actual date of distribution.

These rules are intended to implement Iowa Code sections 124.303, 124.306 to 124.308, 126.10, 155A.13, 155A.31 and 155A.32.

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**15.7(4)** Current medication prescription orders remain in effect when an inmate is transferred within the correctional institution system.

**15.7(5)** Controlled substance records shall be maintained as follows:

*a.* All records for controlled substances shall be maintained in a readily retrievable manner.

*b.* Controlled substance records shall be maintained in a manner to establish receipt and distribution of all controlled substances.

*c.* Records of controlled substances in Schedule II shall be maintained separately from records of controlled substances in Schedules III, IV, and V, and all other records.

*d.* Controlled substances which are issued as unit stock shall be accompanied by a proof-of-use form which provides for documentation of the following information:

(1) Inmate's name and identification number;
(2) Prescriber;
(3) Drug name, strength, and dosage form;
(4) Date and time of administration;
(5) Quantity administered;
(6) Name of individual administering the controlled substance;
(7) Returns to the pharmacy;
(8) Waste, which is required to be witnessed and cosigned by another licensed health professional.

*e.* Invoices involving the distribution of Schedule III, IV, or V controlled substances to another pharmacy or practitioner shall show the actual date of distribution; the name, strength, and quantity of controlled substances distributed; the name, address, and DEA registration number of the distributing pharmacy and of the practitioner or pharmacy receiving the controlled substances.

*f.* Copy 1 of DEA order Form 222, furnished by the pharmacy or practitioner to whom Schedule II controlled substances are distributed, shall be maintained by the distributing pharmacy and shall show the quantity of controlled substances distributed and the actual date of distribution.

*g.* Copy 3 of DEA order Form 222 shall be properly dated, initialed and filed and shall include all copies of each unaccepted or defective order form and any attached statements or other documents.

*h.* If controlled substances, prescription drugs, or nonprescription drug items are listed on the same record, the controlled substances shall be asterisked, red-lined, or in some other manner readily identifiable from all other items appearing on the record.

*i.* Suppliers' invoices of prescription drugs and controlled substances shall clearly record the actual date of receipt by the pharmacist or other responsible individual.

*j.* Suppliers' credit memos for controlled substances and prescription drugs shall be maintained.

*k.* A biennial inventory of controlled substances shall be maintained for a minimum of four years from the date of the inventory.

*l.* Reports of theft or significant loss of controlled substances shall be maintained.

*m.* Reports of surrender or destruction of controlled substances shall be maintained.

**657—15.8(124,126,155A) Drug distribution and dispensing.** Prescription drugs may be distributed or dispensed only from the original or a properly verified practitioner's order.

**15.8(1)** Drugs dispensed in a unit dose dispensing system for subsequent administration by nurses or other qualified individuals shall be packaged and labeled in compliance with the provisions of rule 657—8.9(124,155A).

**15.8(2)** Registered nurses may issue an inmate's prepackaged medications from the supply distributed by the pharmacist for that inmate, into envelopes or other appropriate container to facilitate subsequent administration by other qualified individuals. Said qualified individuals shall use the medication administration record, or a properly verified copy thereof, to administer and document administration of those medications to the inmate. The single unit or unit dose packaging shall remain intact to the point of administration.

**15.8(3)** Drugs dispensed for self-administration by the inmate, either during incarceration or subsequent to the inmate's departure from the department of corrections custody status, shall be packaged and labeled in accordance with rule 657—8.14(155A).

**15.8(4)** Correctional facility pharmacies shall be exempt from the labeling provisions and patient notification requirements of Iowa Code section 155A.32, as respects drugs distributed pursuant to medication prescription orders.

**657—15.9(124,126,155A) Pharmacist in charge.** Each correctional facility pharmacy shall have one pharmacist in charge who shall have the responsibility, at a minimum, for the following:

1. Prepackaging and bulk compounding of drugs in compliance with the provisions of rules 657—8.3(126) and 657—20.11(126);
2. Dispensing and distribution of drugs in compliance with the labeling, record keeping, and other requirements of these rules;
3. Quarterly inspection of all pharmaceuticals located at the correctional facility including emergency and provisional stocks located outside the confines of the pharmacy;
4. Records of all transactions of the correctional facility pharmacy as may be required by applicable state and federal law, and as may be necessary to maintain adequate control over, and accountability for, all pharmaceutical materials;
5. Development, implementation, and review of pharmacy policies and procedures consistent with these rules and existing department of corrections policies relating to pharmaceutical services.

**657—15.10(124,126,155A) Policies and procedures.** Written policies and procedures for the correctional facility pharmacy drug distribution system shall be developed and implemented by the pharmacist in charge of the correctional facility pharmacy consistent with department of corrections policies and procedures pertaining to pharmaceutical services and shall include, but not be limited to, the following:

1. Controlled substances;
2. Formulary or drug list;
3. Stop orders;
4. Drug sample use and distribution;
5. Drug recalls;
6. Outdated drugs;
7. Medication profiles;
8. Inspection of drug inventories;
9. Adverse reaction reports;
10. Furlough or discharge medications;
11. Emergency and provisional stocks of drugs;
12. Drugs brought into the facility;
13. Transfers of drugs between facilities.

**657—15.11(124,126,155A) Orders for medication received in the absence of a pharmacist.**

**15.11(1)** "Provisional stock" is a limited inventory of drugs stored outside the confines of the correctional facility pharmacy and accessible to designated health services staff for the purpose of initiating critical medication prescription orders issued during periods when the pharmacist is unavailable.

**15.11(2)** Whenever prescription drugs or medical devices are obtained in the absence of the pharmacist from the pharmacy or provisional stock, the following is applicable:

*a.* Access to the pharmacy or provisional stock is restricted to those individuals as specified in rule 15.5(124,126,155A);

*b.* Prescription and nonprescription drugs may be removed from the pharmacy or provisional stock only in the original manufacturer's container or in a container prepackaged by the correctional facility pharmacy in accordance with rule 657—8.3(126);

*c.* A record shall be made of all withdrawals by the authorized person removing the drugs, which shall include the following information:

(1) Name and identification number of inmate;

(2) Name, strength, dosage form, and quantity of drug removed;

(3) Date and time of withdrawal of the drug;

(4) Signature or initials of the authorized person making the withdrawal.

*d.* The original or properly verified copy of new medication prescription orders shall be left with the record of withdrawal.

**657—15.12(155A) Training and utilization of pharmacy technicians.** Correctional facility pharmacies utilizing pharmacy technicians shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians. Pharmacy policies shall specify the frequency of review. Technician training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of technician training shall be available for inspection by the board or an agent of the board.

These rules are intended to implement Iowa Code sections 124.303, 124.306, 124.307, 124.308, 126.10, 155A.13, 155A.31, and 155A.32.

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# CHAPTER 19
# NONRESIDENT PHARMACY LICENSES

**657—19.1(155A) Definitions.**

*"Board"* means the Iowa board of pharmacy examiners.

*"Home state"* means the state in which a pharmacy is located.

*"Nonresident pharmacy"* means a pharmacy located outside the state of Iowa which delivers, dispenses, or distributes, by any method, prescription drugs or devices to an ultimate user physically located in this state. "Nonresident pharmacy" shall include a pharmacy located outside the state of Iowa which provides routine pharmacy services to an ultimate user in this state.

*"Nonresident pharmacy license"* means a pharmacy license issued to a nonresident pharmacy.

**657—19.2(155A) Application and license requirements.** A nonresident pharmacy shall apply for and obtain a nonresident pharmacy license from the board prior to delivering, dispensing, or distributing prescription drugs to an ultimate user in this state.

**19.2(1)** A nonresident pharmacy license shall expire on December 31 of each year. The fee for a new or renewal license shall be $100. A nonresident pharmacy license form shall be issued upon receipt of the license application information required in subrule 19.2(2) and payment of the license fee.

Failure to renew the license before January 1 following expiration shall require a renewal fee of $200. Failure to renew the license before February 1 following expiration shall require a renewal fee of $300. Failure to renew the license before March 1 following expiration shall require a renewal fee of $400. Failure to renew the license before April 1 following expiration shall require an appearance before the board and a renewal fee of $500. In no event shall the fee for late renewal of the license exceed $500.

**19.2(2)** A nonresident pharmacy shall submit all of the following in order to obtain or renew a nonresident pharmacy license:

*a.* A completed application form, available from the board, and an application fee of $100.

*b.* Evidence of possession of a valid license, permit, or registration as a pharmacy in compliance with the laws of the home state. Such evidence shall consist of one of the following:

(1) Copy of the current license, permit, or registration certificate issued by the regulatory or licensing agency of the home state;

(2) Letter from the regulatory or licensing agency of the home state certifying the pharmacy's compliance with the pharmacy laws of that state.

*c.* A copy of the most recent inspection report resulting from an inspection conducted by the regulatory or licensing agency of the home state.

*d.* Evidence of correction of any noncompliance noted on inspection reports of the regulatory or licensing agency of the home state and all other regulatory agencies.

*e.* A list of the names, titles, and home addresses of all principal owners, partners, or officers of the nonresident pharmacy.

*f.* A list of the names and license numbers of all pharmacists and, if available, the names and license or registration numbers of all supportive personnel employed by the nonresident pharmacy who deliver, dispense, or distribute, by any method, prescription drugs to an ultimate user in this state, and of the pharmacist in charge of the nonresident pharmacy.

*g.* A copy of the nonresident pharmacy's policies and procedures regarding the records of controlled substances delivered, dispensed, or distributed to ultimate users in this state to be maintained and detailing the format and location of those records.

*h.* A copy of the nonresident pharmacy's policies and procedures evidencing that the pharmacy provides, during its regular hours of operation for at least 6 days and for at least 40 hours per week, toll-free telephone service to facilitate communication between ultimate users in this state and a pharmacist who has access to the ultimate user's records in the nonresident pharmacy, and that the toll-free number is printed on the label affixed to each container of prescription drugs delivered, dispensed, or distributed in this state. A copy of a prescription label including the toll-free number shall be included.

**19.2(3)** A nonresident pharmacy shall update lists required by subrule 19.2(2), paragraphs *"e"* and *"f,"* within 30 days of any addition, deletion, or other change to a list.

**657—19.3(155A) Discipline.** Pursuant to 657—Chapter 9, the board may deny, suspend, or revoke a nonresident pharmacy license for any violation of Iowa Code section 155A.13A; Iowa Code section 155A.15, subsection 2, paragraph *"a," "b," "d," "e," "f," "g," "h,"* or *"i"*; Iowa Code chapter 124, 124A, 124B, 126, or 205; or a rule of the board promulgated thereunder unless the Iowa Code or Iowa Administrative Code conflicts with law, administrative rule, or regulation of the home state. The more stringent of the two shall apply when there is a conflict of law regarding services to Iowa residents.

**657—19.4(155A) Training and utilization of pharmacy technicians.** Nonresident pharmacies utilizing pharmacy technicians shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians. Pharmacy policies shall specify the frequency of review. Technician training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of technician training shall be available for inspection by the board or an agent of the board.

**657—19.5(135C,155A) Personnel histories.** Pursuant to the requirements of Iowa Code section 135C.33, the provisions of this rule shall apply to any pharmacy employing any person to provide patient care services in a patient's home within the state of Iowa. For the purposes of this rule, "employed by the pharmacy" shall include any individual who is paid, either by the pharmacy or by any other entity such as a corporate entity, a temporary agency, or an independent contractor, to provide treatment or services to any patient in the patient's home in Iowa. Specifically excluded from the requirements of this rule are individuals such as delivery persons or couriers who do not enter the patient's home for the purpose of instructing the patient or the patient's caregiver in the use or maintenance of the equipment, device, or medication being delivered, or who do not enter the patient's home for the purpose of setting up or servicing the equipment, device, or medication used to treat the patient in the patient's home.

**19.5(1)** *Applicants questioned, informed.* The pharmacy shall ask the following question of each person seeking employment in a position which will provide in-home services in Iowa: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?" The applicant shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The applicant shall indicate, by signed acknowledgment, that the applicant has been informed that such record checks will be conducted.

**19.5(2)** *Procedures and forms.* Prior to the employment of any person to provide in-home services in Iowa, the pharmacy shall submit a form specified by the department of public safety to the department of public safety and receive the results of a criminal history check and dependent adult abuse record check. The pharmacy may submit a form specified by the department of human services to the department of human services to request a child abuse history check.

**19.5(3)** *Employment prohibition—exception.* A person who has a criminal record, founded dependent adult abuse report, or founded child abuse report shall not be employed by a pharmacy to provide in-home services in Iowa unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse does not merit prohibition from such employment.

**19.5(4)** *Records.* The pharmacy shall keep copies of all record checks and evaluations.

These rules are intended to implement Iowa Code section 155A.13A.

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**657—22.11(155A) Identification of pharmacy technician.**

**22.11(1)** *Name badge.* A pharmacy technician shall wear a name badge or other form of identification while on duty which clearly identifies the person as such.

**22.11(2)** *Misrepresentation prohibited.* A pharmacy technician shall not represent himself or herself as a pharmacist in any manner.

**657—22.12(155A) Tasks a pharmacy technician shall not perform.** A pharmacy technician shall not:

1. Provide the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order;
2. Conduct prospective drug use review or evaluate a patient's medication record for purposes identified in rule 657—8.19(155A);
3. Provide patient counseling, consultation, or patient-specific drug information;
4. Make decisions that require a pharmacist's professional judgment such as interpreting or applying information.

**657—22.13(155A) Delegation of technical functions.** A pharmacist may delegate technical dispensing functions to a pharmacy technician, but only if the pharmacist is on site when delegated functions are performed, except as provided in 657—subrule 6.6(2). The pharmacist shall provide the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription prior to the delivery of the prescription to the patient or the patient's representative.

**657—22.14(155A) Technical functions.** At the discretion of the supervising pharmacist, technical functions which may be delegated to a pharmacy technician include, but are not limited to, the following:

1. Performing packaging, manipulative, or repetitive tasks relating to the processing of a prescription or medication order in a licensed pharmacy.
2. Accepting prescription refill authorizations communicated to a pharmacy by a prescriber or by the prescriber's office.
3. Contacting prescribers to obtain prescription refill authorizations.
4. Collecting pertinent patient information.
5. Inspecting drug supplies provided and controlled by an Iowa-licensed pharmacy, including but not limited to drug supplies maintained in an ambulance or other emergency medical service vehicle, a long-term care facility, a hospital nursing unit, or a hospice facility.

**657—22.15(155A) New prescription drug orders or medication orders.** At the discretion of the supervising pharmacist, a pharmacy technician may be allowed to accept new prescription drug orders or medication orders communicated to the pharmacy by a prescriber or by the prescriber's agent if the pharmacy technician has received appropriate training pursuant to the pharmacy's policies and procedures. The supervising pharmacist shall remain responsible for ensuring the accuracy, validity, and completeness of the information received by the pharmacy technician.

**657—22.16(155A) Training and utilization of pharmacy technicians.** All Iowa-licensed pharmacies utilizing pharmacy technicians shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians. Pharmacy policies shall specify the frequency of review. Technician training shall be documented and maintained by the pharmacy for the duration of employment. Such policies and procedures and documentation of technician training shall be available for inspection by the board or an agent of the board.

**657—22.17(155A) Certification of pharmacy technicians.** The certification and recertification of pharmacy technicians shall be voluntary and not mandatory. Pharmacy technician certification does not supplant the need for licensed pharmacist control over the performance of delegated functions.

**657—22.18(155A) Discipline of pharmacy technicians.**

**22.18(1)** *Violations.* The board may impose discipline for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs, or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A, or 205, or any rule of the board.

**22.18(2)** *Sanctions.* The board may impose the following disciplinary sanctions:

*a.* Revocation of a pharmacy technician registration.

*b.* Suspension of a pharmacy technician registration until further order of the board or for a specified period.

*c.* Nonrenewal of a pharmacy technician registration.

*d.* Prohibit permanently, until further order of the board, or for a specified period, the engaging in specified procedures, methods or acts.

*e.* Probation.

*f.* Impose civil penalties not to exceed $25,000.

*g.* Issue citation and warning.

*h.* Such other sanctions allowed by law as may be appropriate.

**657—22.19(155A) Responsibility of supervising pharmacist.** The ultimate responsibility for the actions of a pharmacy technician working under a supervising pharmacist shall remain with the supervising pharmacist.

**657—22.20(155A) Persons exempt from registration.** Other health care providers who assist in the technical functions of the practice of pharmacy and who are actively licensed or registered as a physician, a physician's assistant, an advanced registered nurse practitioner, a nurse, a pharmacist, or a pharmacist-intern, are exempt from registration as a pharmacy technician.

**657—22.21(147,155A) Unethical conduct or practice.** Violation by a pharmacy technician of any of the provisions of this rule shall constitute unethical conduct or practice and may be grounds for disciplinary action as provided in 657—22.18(155A).

**22.21(1)** *Misrepresentative deeds.* A pharmacy technician shall not make any statement tending to deceive, misrepresent or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.

**22.21(2)** *Confidentiality.* In the absence of express consent from the patient or order or direction of a court, except where the best interests of the patient require, a pharmacy technician shall not divulge or reveal to any person other than the patient or the patient's authorized representative, the prescriber or other licensed practitioner then caring for the patient, a licensed pharmacist, or a person duly authorized by law to receive such information, the contents of any prescription or the therapeutic effect thereof or the nature of professional pharmaceutical services rendered to a patient; the nature, extent, or degree of illness suffered by any patient; or any medical information furnished by the prescriber.

**22.21(3)** *Discrimination.* It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, sex, age, national origin, or disease state when providing pharmaceutical services.

**22.21(4)** *Unethical conduct or behavior.* A pharmacy technician shall not exhibit unethical behavior in connection with the technician's pharmacy employment. Unethical behavior shall include, but is not limited to, the following acts: verbal abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

This rule is intended to implement Iowa Code sections 147.55, 155A.6, and 155A.23.

These rules are intended to implement Iowa Code sections 155A.3, 155A.6, and 155A.33.

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CHAPTERS 23 and 24
Reserved

## CHAPTER 25
## CHILD SUPPORT NONCOMPLIANCE

**657—25.1(252J) Definitions.** For the purpose of this chapter the following definitions shall apply:

*"Act"* means Iowa Code chapter 252J.

*"Board"* means the Iowa board of pharmacy examiners.

*"Certificate"* means a document known as a certificate of noncompliance which is provided by the child support unit certifying that the named licensee is not in compliance with a support order or with a written agreement for payment of support entered into by the child support unit and the licensee.

*"Child support unit"* means the child support recovery unit of the Iowa department of human services.

*"Denial notice"* means a board notification denying an application for the issuance or renewal of a license as required by the Act.

*"License"* means a license to practice pharmacy, a registration to practice as a pharmacist-intern, a registration to practice as a pharmacy technician, or a registration to possess, prescribe, dispense, administer, distribute, or otherwise handle controlled substances under Iowa Code chapter 124.

*"Licensee"* means an individual to whom a license has been issued or who is seeking the issuance of a license.

*"Revocation or suspension notice"* means a board notification suspending a license for an indefinite or specified period of time or a notification revoking a license as required by the Act.

*"Withdrawal certificate"* means a document known as a withdrawal of a certificate of noncompliance provided by the child support unit certifying that the certificate is withdrawn and that the board may proceed with issuance, reinstatement, or renewal of a license.

**657—25.2(252J) Issuance or renewal of license—denial.** The board shall deny the issuance or renewal of a license upon the receipt of a certificate from the child support unit. This rule shall apply in addition to the procedures set forth in the Act.

**25.2(1)** *Service of denial notice.* Notice shall be served upon the licensee by certified mail, return receipt requested; by personal service; or through authorized counsel.

**25.2(2)** *Effective date of denial.* The effective date of the denial of issuance or renewal of a license, as specified in the notice, shall be 60 days following service of the notice upon the licensee.

**25.2(3)** *Preparation and service of denial notice.* The executive secretary/director of the board is authorized to prepare and serve the notice upon the licensee.

**25.2(4)** *Licensee responsible to inform board.* Licensees shall keep the board informed of all court actions and all child support unit actions taken under or in connection with the Act and shall provide the board with copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and any withdrawal certificates issued by the child support unit.

**25.2(5)** *Reinstatement following license denial.* All board fees required for application, license renewal, or license reinstatement shall be paid by licensees before a license will be issued, renewed, or reinstated after the board has denied the issuance or renewal of a license pursuant to the Act.

**25.2(6)** *Effect of filing in district court.* In the event a licensee files a timely district court action following service of a notice, the board shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the denial of the issuance or renewal of a license, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

25.2(7) *Final notification.* The board shall notify the licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the denial of the issuance or renewal of a license and shall similarly notify the licensee if the license is issued or renewed following the board's receipt of a withdrawal certificate.

**657—25.3(252J) Suspension or revocation of a license.** The board shall suspend or revoke a license upon the receipt of a certificate from the child support unit according to the procedures set forth in the Act. This rule shall apply in addition to the procedures set forth in the Act.

25.3(1) *Service of revocation or suspension notice.* Revocation or suspension notice shall be served upon the licensee by certified mail, return receipt requested; by personal service; or through authorized counsel.

25.3(2) *Effective date of revocation or suspension.* The effective date of the suspension or revocation of a license, as specified in the revocation or suspension notice, shall be 60 days following service of the revocation or suspension notice upon the licensee.

25.3(3) *Preparation and service of revocation or suspension notice.* The executive secretary/director of the board is authorized to prepare and serve the revocation or suspension notice upon the licensee and is directed to notify the licensee that the license will be suspended unless the license is already suspended on other grounds. In the event that the license is on suspension, the executive secretary/director shall notify the licensee of the board's intention to revoke the license.

25.3(4) *Licensee responsible to inform board.* The licensee shall keep the board informed of all court actions and all child support unit action taken under or in connection with the Act and shall provide the board with copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and any withdrawal certificates issued by the child support unit.

25.3(5) *Reinstatement following license suspension or revocation.* A licensee shall pay all board fees required for license renewal or license reinstatement, and all continuing education requirements shall be met, before a license will be reinstated after the board has suspended a license pursuant to the Act. A licensee whose license to practice pharmacy has been revoked shall complete the examination components as indicated in 657—2.10(155A) and shall pay all required examination fees pursuant to 657—2.2(147). A licensee whose registration to practice as a pharmacist-intern or as a pharmacy technician or whose registration to handle controlled substances under Iowa Code chapter 124 has been revoked shall complete application and pay all board fees required for new registration.

25.3(6) *Effect of filing in district court.* In the event a licensee files a timely district court action pursuant to the Act and following service of a revocation or suspension notice, the board shall continue with the intended action described in the revocation or suspension notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the suspension or revocation, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

25.3(7) *Final notification.* The board shall notify the licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a license and shall similarly notify the licensee if a license is reinstated following the board's receipt of a withdrawal certificate.

**657—25.4(17A,22,252J) Share information.** Notwithstanding any statutory confidentiality provision, the board may share information with the child support unit through manual or automated means for the sole purpose of identifying applicants or licensees subject to enforcement under the Act.

These rules are intended to implement Iowa Code chapter 252J.

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# CHAPTER 31
# STUDENT LOAN DEFAULT OR NONCOMPLIANCE WITH AGREEMENT FOR PAYMENT OF OBLIGATION

**657—31.1(261) Definitions.** For the purpose of this chapter, the following definitions shall apply:

"*Act*" means Iowa Code sections 261.121 to 261.127.

"*Board*" means the Iowa board of pharmacy examiners.

"*Certificate*" means a document known as a certificate of noncompliance from the college student aid commission certifying that the named licensee is not in compliance with the terms of an agreement for payment of a student loan obligation.

"*Commission*" means the college student aid commission.

"*Denial notice*" means a board notification denying an application for the issuance or renewal of a license as required by the Act.

"*License*" means a license to practice pharmacy, a registration to practice as a pharmacist-intern, a registration to practice as a pharmacy technician, or a registration to possess, prescribe, dispense, administer, distribute, or otherwise handle controlled substances under Iowa Code chapter 124.

"*Licensee*" means an individual to whom a license has been issued or who is seeking the issuance of a license.

"*Revocation or suspension notice*" means a board notification suspending a license for an indefinite or specified period of time or a notification revoking a license as required by the Act.

"*Withdrawal certificate*" means a document known as a withdrawal of a certificate of noncompliance provided by the commission certifying that the certificate is withdrawn and that the board may proceed with issuance, reinstatement, or renewal of a license.

**657—31.2(261) Issuance or renewal of a license—denial.** The board shall deny the issuance or renewal of a license upon receipt of a certificate from the commission according to the procedures set forth in Iowa Code sections 261.121 to 261.127.

**31.2(1)** *Service of denial notice.* Notice shall be served upon the licensee by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the licensee may accept service personally or through authorized counsel.

**31.2(2)** *Effective date of denial.* The effective date of the denial of issuance or renewal of a license, as specified in the notice, shall be 60 days following service of the notice upon the licensee.

**31.2(3)** *Preparation and service of denial notice.* The executive secretary/director of the board is authorized to prepare and serve the notice upon the licensee.

**31.2(4)** *Licensee responsible to inform board.* Licensees shall keep the board informed of all court actions and all commission actions taken under or in connection with the Act and shall provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 261.127, all court orders entered in such actions, and any withdrawal certificates issued by the commission.

**31.2(5)** *Reinstatement following license denial.* All board fees required for application, license renewal, or license reinstatement shall be paid by licensees, and all continuing education requirements shall be met, before a license will be issued, renewed, or reinstated after the board has denied the issuance or renewal of a license pursuant to the Act.

**31.2(6)** *Effect of filing in district court.* In the event a licensee timely files a district court action following service of a board notice pursuant to Iowa Code sections 261.126 and 261.127, the board shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the denial of the issuance or renewal of a license, the board shall count the number of days before the action was filed and the number of days after the action was disposed by the court.

31.2(7) *Final notification.* The board shall notify the licensee in writing through regular first-class mail, or such other means as the board deems appropriate in the circumstances, within ten days of the effective date of the denial of the issuance or renewal of a license and shall similarly notify the licensee when the license is issued or renewed following the board's receipt of a withdrawal certificate.

**657—31.3(261) Suspension or revocation of a license.** The board shall suspend or revoke a license upon receipt of a certificate from the commission according to the procedures set forth in the Act. This rule shall apply in addition to the procedures set forth in the Act.

31.3(1) *Service of revocation or suspension notice.* Notice shall be served upon the licensee by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the licensee may accept service personally or through authorized counsel.

31.3(2) *Effective date of revocation or suspension.* The effective date of the revocation or suspension of a license, as specified in the notice, shall be 60 days following service of the notice upon the licensee.

31.3(3) *Preparation and service of revocation or suspension notice.* The executive secretary/director of the board is authorized to prepare and serve the notice upon the licensee and is directed to notify the licensee that the license will be suspended unless the license is already suspended on other grounds. In the event that the license is on suspension, the executive secretary/director shall notify the licensee of the board's intention to revoke the license.

31.3(4) *Licensee responsible to inform board.* Licensees shall keep the board informed of all court actions and all commission actions taken under or in connection with the Act and shall provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 261.127, all court orders entered in such actions, and any withdrawal certificates issued by the commission.

31.3(5) *Reinstatement following license suspension or revocation.* All board fees required for license renewal or license reinstatement shall be paid by licensees, and all continuing education requirements shall be met, before a license will be renewed or reinstated after the board has suspended a license pursuant to the Act. A licensee whose license to practice pharmacy has been revoked shall complete the examination components as indicated in rule 657—2.10(155A) and shall pay all required examination fees pursuant to rule 657—2.2(147). A licensee whose registration to practice as a pharmacist-intern or as a pharmacy technician or whose registration to handle controlled substances under Iowa Code chapter 124 has been revoked shall complete application and pay all board fees required for new registration.

31.3(6) *Effect of filing in district court.* In the event a licensee timely files a district court action following service of a board notice pursuant to Iowa Code sections 261.126 and 261.127, the board shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the suspension or revocation of a license, the board shall count the number of days before the action was filed and the number of days after the action was disposed by the court.

31.3(7) *Final notification.* The board shall notify the licensee in writing through regular first-class mail, or such other means as the board deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a license and shall similarly notify the licensee when the license is reinstated following the board's receipt of a withdrawal certificate.

**657—31.4(17A,22,261) Share information.** Notwithstanding any statutory confidentiality provision, the board may share information with the commission through manual or automated means for the sole purpose of identifying applicants or licensees subject to enforcement under the Act.

These rules are intended to implement Iowa Code sections 261.121 to 261.127.

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TITLE IX
*PROPERTY*

CHAPTER 71
ASSESSMENT PRACTICES
AND EQUALIZATION

71.1(405,427A,428,441) Classification of real estate
71.2(421,428,441) Assessment and valuation of real estate
71.3(421,428,441) Valuation of agricultural real estate
71.4(421,428,441) Valuation of residential real estate
71.5(421,428,441) Valuation of commercial real estate
71.6(421,428,441) Valuation of industrial land and buildings
71.7(421,427A,428,441) Valuation of industrial machinery
71.8(428,441) Abstract of assessment
71.9(428,441) Reconciliation report
71.10(421) Assessment/sales ratio study
71.11(441) Equalization of assessments by class of property
71.12(441) Determination of aggregate actual values
71.13(441) Tentative equalization notices
71.14(441) Hearings before the director
71.15(441) Final equalization order
71.16(441) Alternative method of implementing equalization orders
71.17(441) Special session of boards of review
71.18(441) Judgment of assessors and local boards of review
71.19(441) Conference boards
71.20(441) Board of review
71.21(428,441) Assessors
71.22 to 71.24 Reserved
71.25(441,443) Omitted assessments

CHAPTER 72
EXAMINATION AND CERTIFICATION
OF ASSESSORS AND
DEPUTY ASSESSORS

72.1(441) Application for examination
72.2(441) Examinations
72.3(441) Equivalent of high school diploma
72.4(441) Appraisal-related experience
72.5(441) Regular certification
72.6(441) Temporary certification
72.7(441) Restricted certification
72.8(441) Deputy assessors—regular certification
72.9(441) Deputy assessors—restricted certification
72.10(441) Appointment of deputy assessors
72.11(441) Special examinations
72.12(441) Register of eligible candidates
72.13(441) Course of study for provisional appointees
72.14(441) Examining board
72.15(441) Appointment of assessor
72.16(441) Reappointment of assessor
72.17(441) Removal of assessor
72.18(421,441) Courses offered by the department of revenue and finance

CHAPTER 73
PROPERTY TAX CREDIT AND
RENT REIMBURSEMENT


73.1(425) Eligible claimants
73.2(425) Separate homesteads—husband and wife property tax credit
73.3(425) Dual claims
73.4(425) Multipurpose building
73.5(425) Multidwelling
73.6(425) Income
73.7(425) Joint tenancy
73.8(425) Amended claim
73.9(425) Simultaneous homesteads
73.10(425) Confidential information
73.11(425) Mobile, modular, and manufactured homes
73.12(425) Totally disabled
73.13(425) Nursing homes
73.14(425) Household
73.15(425) Homestead
73.16(425) Household income
73.17(425) Timely filing of claims
73.18(425) Separate homestead—husband and wife rent reimbursements
73.19(425) Gross rent/rent constituting property taxes paid
73.20(425) Leased land
73.21(425) Property: Taxable status
73.22(425) Special assessments
73.23(425) Suspended, delinquent, or canceled taxes
73.24(425) Income: Spouse
73.25(425) Common law marriage
73.26 Reserved
73.27(425) Special assessment credit
73.28(425) Credit applied
73.29(425) Deceased claimant
73.30(425) Audit of claim
73.31(425) Extension of time for filing a claim
73.32(425) Annual adjustment factor


CHAPTER 74
MOBILE, MODULAR, AND
MANUFACTURED HOME TAX


74.1(435) Definitions
74.2(435) Movement of home to another county
74.3(435) Sale of home
74.4(435) Reduced tax rate
74.5(435) Taxation—real estate
74.6(435) Taxation—square footage
74.7(435) Audit by department of revenue and finance
74.8(435) Collection of tax


CHAPTER 75
PROPERTY TAX ADMINISTRATION


75.1(441) Tax year
75.2(445) Partial payment of tax
75.3(445) When delinquent
75.4(446) Payment of subsequent year taxes by purchaser
75.5(428,433,434,437,438) Central assessment confidentiality


CHAPTER 76
DETERMINATION OF VALUE
OF RAILROAD COMPANIES


76.1(434) Definitions of terms
76.2(434) Filing of annual reports
76.3(434) Comparable sales
76.4(434) Stock and debt approach to unit value
76.5(434) Income capitalization approach to unit value
76.6(434) Cost approach to unit value
76.7(434) Correlation
76.8(434) Allocation of unit value to state
76.9(434) Exclusions

TITLE IX
*PROPERTY*

# CHAPTER 71
# ASSESSMENT PRACTICES AND EQUALIZATION
[Prior to 12/17/86, Revenue Department[730]]

**701—71.1(405,427A,428,441) Classification of real estate.**

**71.1(1)** *Responsibility of assessors.* All real estate subject to assessment by city and county assessors shall be classified as provided in this rule. It shall be the responsibility of city and county assessors to determine the proper classification of real estate. The determination shall be based upon the best judgment of the assessor following the guidelines set forth in this rule and the status of the real estate as of January 1 of the year in which the assessment is made. See subrule 71.1(8) for an exception to the general rule that property is to be classified according to its use. The classification shall be utilized on the abstract of assessment submitted to the department of revenue and finance pursuant to Iowa Code section 441.45. See rule 71.8(428,441).

**71.1(2)** *Responsibility of boards of review, county auditors, and county treasurers.* Whenever local boards of review, county auditors, and county treasurers exercise assessment functions allowed or required by law, they shall classify property as provided in this rule and adhere to the requirements of this rule.

**71.1(3)** *Agricultural real estate.* Agricultural real estate shall include all tracts of land and the improvements and structures located on them which are in good faith used primarily for agricultural purposes except buildings which are primarily used or intended for human habitation as defined in subrule 71.1(4). Land and the nonresidential improvements and structures located on it shall be considered to be used primarily for agricultural purposes if its principal use is devoted to the raising and harvesting of crops or forest or fruit trees, the rearing, feeding, and management of livestock, or horticulture, all for intended profit.

Agricultural real estate shall also include woodland, wasteland, and pastureland, but only if that land is held or operated in conjunction with agricultural real estate as defined in this subrule.

**71.1(4)** *Residential real estate.* Residential real estate shall include all lands and buildings which are primarily used or intended for human habitation, including those buildings located on agricultural land. Buildings used primarily or intended for human habitation shall include the dwelling as well as structures and improvements used primarily as a part of, or in conjunction with, the dwelling. This includes but is not limited to garages, whether attached or detached, tennis courts, swimming pools, guest cottages, and storage sheds for household goods. Residential real estate located on agricultural land shall include only buildings as defined in this subrule. Buildings for human habitation that are used as commercial ventures, including but not limited to hotels, motels, rest homes, condominiums, and structures containing three or more separate living quarters shall not be considered residential real estate. However, regardless of the number of separate living quarters, condominiums not used as commercial ventures, multiple housing cooperatives organized under Iowa Code chapter 499A, and land and buildings owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be considered residential real estate. Effective January 1, 2000, property shall be classified as residential real estate if a majority of the condominiums are or will be used for residential purposes and have been sold, are available for sale, or are being rented, but the primary intent of the owner is to sell the units. For example, a building containing 25 condominiums of which 22 have been sold, are available for sale, or are being rented, but the primary intent of the owner is to sell the units, shall be classified as residential real estate. If more than one building is included in the horizontal property regime, the number of condominiums shall be combined to determine the majority use.

**71.1(5)** *Commercial real estate.* Commercial real estate shall include all lands and improvements and structures located thereon which are primarily used or intended as a place of business where goods, wares, services, or merchandise is stored or offered for sale at wholesale or retail. Commercial realty shall also include hotels, motels, rest homes, condominiums, structures consisting of three or more separate living quarters and any other buildings for human habitation that are used as a commercial venture. Commercial real estate shall also include data processing equipment as defined in Iowa Code section 427A.1(1)*"j,"* except data processing equipment used in the manufacturing process. However, regardless of the number of separate living quarters or any commercial use of the property, single- and two-family dwellings, multiple housing cooperatives organized under Iowa Code chapter 499A, and land and buildings used primarily for human habitation and owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be classified as residential real estate, as shall condominiums not used as commercial ventures. Effective January 1, 2000, property shall be classified as commercial real estate if a majority of the condominiums are being used as a business or used for residential purposes and not sold, not available for sale, or are rented and the primary intent of the owner is to continue renting rather than sell the units. For example, a building containing 25 condominiums of which 22 are being used as businesses or used for residential purposes and not sold, not available for sale, or are rented and the primary intent of the owner is to continue renting rather than sell the units, is to be classified as commercial real estate. If more than one building is included in the horizontal property regime, the number of condominiums shall be combined to determine the majority use.

**71.1(6)** *Industrial real estate.*

*a. Land and buildings.*

(1) Industrial real estate includes land, buildings, structures, and improvements used primarily as a manufacturing establishment. A manufacturing establishment is a business entity in which the primary activity consists of adding to the value of personal property by any process of manufacturing, refining, purifying, the packing of meats, or the combination of different materials with the intent of selling the product for gain or profit. Industrial real estate includes land and buildings used for the storage of raw materials or finished products and which are an integral part of the manufacturing establishment, and also includes office space used as part of a manufacturing establishment.

(2) Whether property is used primarily as a manufacturing establishment and, therefore, assessed as industrial real estate depends upon the extent to which the property is used for the activities enumerated in subparagraph 71.1(6)*"a"*(1). Property in which the performance of these activities is only incidental to the property's primary use for another purpose is not a manufacturing establishment. For example, a grocery store in which bakery goods are prepared would be assessed as commercial real estate since the primary use of the grocery store premises is for the sale of goods not manufactured by the grocery and the industrial activity, i.e., baking, is only incidental to the store premises' primary use. However, property which is used primarily as a bakery would be assessed as industrial real estate even if baked goods are sold at retail on the premises since the bakery premises' primary use would be for an industrial activity to which the retail sale of baked goods is merely incidental. See *Lichty v. Board of Review of Waterloo,* 230 Iowa 750, 298 N.W. 654 (1941).

Similarly, a facility which has as its primary use the mixing and blending of products to manufacture feed would be assessed as industrial real estate even though a portion of the facility is used solely for the storage of grain, if the use for storage is merely incidental to the property's primary use as a manufacturing establishment. Conversely, a facility used primarily for the storage of grain would be assessed as commercial real estate even though a part of the facility is used to manufacture feed. In the latter situation, the industrial use of the property — the manufacture of feed — is merely incidental to the property's primary use for commercial purposes — the storage of grain.

(3) Property used primarily for the extraction of rock or mineral substances from the earth is not a manufacturing establishment if the only processing performed on the substance is to change its size by crushing or pulverizing. See *River Products Company v. Board of Review of Washington County,* 332 N.W.2d 116 (Iowa Ct. App. 1982).

*b. Machinery.*

(1) Machinery includes equipment and devices, both automated and nonautomated, which is used in manufacturing as defined in Iowa Code section 428.20. See *Deere Manufacturing Co. v. Beiner,* 247 Iowa 1264, 78 N.W.2d 527 (1956).

(2) Machinery owned or used by a manufacturer but not used within the manufacturing establishment is not assessed as industrial real estate. For example, "X" operates a factory which manufactures building materials for sale. In addition, "X" uses some of these building materials in construction contracts. The machinery which "X" would primarily use at the construction site would not be used in a manufacturing establishment and, therefore, would not be assessed as industrial real estate.

(3) Machinery used in manufacturing but not used in or by a manufacturing establishment is not assessed as industrial real estate. See *Associated General Contractors of Iowa v. State Tax Commission,* 255 Iowa 673, 123 N.W.2d 922 (1963).

(4) Where the primary function of a manufacturing establishment is to manufacture personal property that is consumed by the manufacturer rather than sold, the machinery used in the manufacturing establishment is not assessed as industrial real estate. See *Associated General Contractors of Iowa v. State Tax Commission,* 255 Iowa 673, 123 N.W.2d 922 (1963).

**71.1(7)** *Point-of-sale equipment.* As used in Iowa Code section 427A.1(1)*"j,"* the term "point-of-sale equipment" means input, output, and processing equipment used to consummate a sale and to record or process information pertaining to a sale transaction at the time the sale takes place and which is located at the counter, desk, or other specific point at which the transaction occurs. As used in this subrule, the term "sale" means the sale or rental of goods or services and includes both retail and wholesale transactions. Point-of-sale equipment does not include equipment used primarily for depositing or withdrawing funds from financial institution accounts.

**71.1(8)** *Housing development property.* A county board of supervisors may adopt an ordinance providing that property acquired and subdivided for development of housing be classified the same as it was prior to its acquisition until the property is sold or, depending on a county's population, for a specified number of years from the date of subdivision, whichever is shorter. The applicable time period is five years in counties with a population of less than 20,000 and three years in counties with a population of 20,000 or more. The property is to be classified as residential or commercial, whichever is applicable, in the assessment year following the year in which it is sold or the applicable time period has expired. For purposes of this subrule, "subdivided" means to divide a tract of land into three or more lots.

This rule is intended to implement Iowa Code sections 405.1, 427A.1, 428.4, 441.21, and 441.22.

**701—71.2(421,428,441) Assessment and valuation of real estate.**

**71.2(1)** *Responsibility of assessor.* The valuation of real estate as established by city and county assessors shall be the actual value of the real estate as of January 1 of the year in which the assessment is made. New parcels of real estate created by the division of existing parcels of real estate shall be assessed separately as of January 1 of the year following the division of the existing parcel of real estate.

**71.2(2)** *Responsibility of other assessing officials.* Whenever local boards of review, county auditors, and county treasurers exercise assessment functions allowed or required by law, they shall follow the provisions of subrule 71.2(1) and rules 71.3(421,428,441) to 71.7(421,427A,428,441).

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

**701—71.3(421,428,441) Valuation of agricultural real estate.** Agricultural real estate shall be assessed at its actual value as defined in Iowa Code section 441.21 by giving exclusive consideration to its productivity and net earning capacity. In determining the actual value of agricultural real estate, city and county assessors shall use the "Iowa Real Property Appraisal Manual" and any other guidelines issued by the department of revenue and finance pursuant to Iowa Code section 421.17(18).

In determining the productivity and net earning capacity of agricultural real estate the assessor shall also use available data from Iowa State University, the Iowa crop and livestock reporting service, the department of revenue and finance, or other reliable sources. The assessor shall also consider the results of a modern soil survey, if completed.

The assessor shall determine the actual valuation of agricultural real estate within the assessing jurisdiction and spread such valuation throughout the jurisdiction so that each parcel of real estate is assessed at its actual value as defined in Iowa Code section 441.21.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

**701—71.4(421,428,441) Valuation of residential real estate.** Residential real estate shall be assessed at its actual value as defined in Iowa Code section 441.21.

In determining the actual value of residential real estate, city and county assessors shall use the appraisal manual issued by the department of revenue and finance pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

**701—71.5(421,428,441) Valuation of commercial real estate.** Commercial real estate shall be assessed at its actual value as defined in Iowa Code section 441.21. The director of revenue and finance shall assess the property of long distance telephone companies as defined in Iowa Code section 476.1D(10) which property is first assessed for taxation on or after January 1, 1996, in the same manner as commercial real estate.

In determining the actual value of commercial real estate, city and county assessors shall use the appraisal manual issued by the department of revenue and finance pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4, 441.21 and Iowa Code section 476.1D(10) as amended by 1995 Iowa Acts, House File 518.

**701—71.6(421,428,441) Valuation of industrial land and buildings.** Industrial real estate shall be assessed at its actual value as defined in Iowa Code section 441.21.

In determining the actual value of industrial land and buildings, city and county assessors shall use the appraisal manual issued by the department of revenue and finance pursuant to Iowa Code subsection 421.17(18), and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

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CHAPTER 431
VEHICLE RECYCLERS

431.1(321H) Definitions
431.2(321H) Criteria for obtaining a vehicle recycler license
431.3(321H) Firm name
431.4(321H) Denial, suspension or revocation of license
431.5(321) Right of inspection

CHAPTERS 432 to 449
Reserved

CHAPTER 450
MOTOR VEHICLE EQUIPMENT

450.1(321) Safety standards for motor vehicle equipment
450.2(321) Equipment requirements for specially constructed, reconstructed and kit motor vehicles, other than motorcycles
450.3(321) Mud and snow tire
450.4(321) Minimum requirements for constructing and equipping specially constructed or reconstructed motorcycles
450.5 Reserved
450.6(321) Safety requirements for the movement of implements of husbandry by retail sellers and manufacturers
450.7(321) Front windshields, windows or sidewings

CHAPTER 451
EMERGENCY VEHICLE PERMITS

451.1(321) Address
451.2(321) Authorized emergency vehicle certificate

CHAPTER 452
FLASHING LIGHTS AND WARNING DEVICES ON SLOW-MOVING VEHICLES

452.1(321) Slow-moving vehicle
452.2(321) Required equipment

CHAPTER 453
WEIGHT EQUALIZING HITCH AND SWAY CONTROL DEVICES FOR TRAILERS

453.1(321) Definitions
453.2(321) Weight equalizing hitches
453.3(321) Sway control devices

CHAPTER 454
TOWING WRECKED OR DISABLED VEHICLES

454.1(321) Definitions

CHAPTERS 455 to 479
Reserved

CHAPTER 480
ABANDONED VEHICLES

480.1(321) Definitions
480.2(321) Location
480.3(321) Disposal by police authority
480.4(321) Disposal by private entity

CHAPTERS 481 to 499
Reserved

*MOTOR CARRIERS*

CHAPTER 500
INTERSTATE REGISTRATION AND OPERATION OF VEHICLES

500.1(326) Definitions
500.2(326) General information
500.3(326) General course and method of operation
500.4(326) Trip-leased vehicle
500.5 and 500.6 Reserved
500.7(321,326) Policy on registration credit
500.8(326) Cancellation for nonpayment of registration fees
500.9(326) Voluntary cancellation of registration
500.10(321,326) Monthly penalty
500.11(326) Temporary authority
500.12(321,326) Making claim for refund
500.13(326) Late applications
500.14(321) Payment of first half fee
500.15 Reserved
500.16(326) Registration of vehicles with non-Iowa titles
500.17(326) Prorate plate
500.18 and 500.19 Reserved
500.20(326) Record retention

CHAPTERS 501 to 504
Reserved

CHAPTER 505
INTERSTATE MOTOR VEHICLE
FUEL PERMITS

505.1(452A) Definitions
505.2(452A) General information
505.3(452A) General stipulations
505.4(452A) Quarterly reports
505.5(452A) Audits—required records
505.6(452A) Hearings

CHAPTERS 506 to 510
Reserved

CHAPTER 511
SPECIAL PERMITS FOR OPERATION AND
MOVEMENT OF VEHICLES AND LOADS
OF EXCESS SIZE AND WEIGHT

511.1(321E) Definitions
511.2(321E) Location and general information
511.3(321E) Movement under permit
511.4(321E) Permits
511.5(321E) Fees and charges
511.6(321E) Insurance and bonds
511.7(321,321E) Issuance of annual permits
511.8(321,321E) Issuance of all-system permits
511.9(321,321E) Multitrip permits
511.10(321,321E) Issuance of single-trip permits
511.11(321,321E) Maximum axle weights and maximum gross weights for vehicles and loads moved under permit
511.12(321,321E) Movement of vehicles with divisible loads exceeding statutory size or weight limits
511.13(321E) Towing units
511.14 Reserved
511.15(321E) Escorting
511.16(321,321E) Permit violations

CHAPTER 512
Reserved

CHAPTER 513
COMPACTED RUBBISH VEHICLE
PERMITS

513.1(321) Definitions
513.2(321) General stipulations
513.3(321) Application
513.4(321) Replacement permit
513.5(321) Permit violations

CHAPTERS 514 to 519
Reserved

CHAPTER 520
REGULATIONS APPLICABLE
TO CARRIERS

520.1(321) Safety and hazardous materials regulations
520.2(321) Definitions
520.3(321) Motor carrier safety regulations exemptions
520.4(321) Hazardous materials exemptions
520.5 Reserved
520.6(307,321) Out-of-service order
520.7(321) Driver's statement

CHAPTERS 521 and 522
Reserved

CHAPTER 523
TRUCK OPERATORS AND
CONTRACT CARRIERS

523.1(327) General information
523.2(327) Applications and filings
523.3(325,327) Marking of motor vehicles
523.4(327) Insurance—suspension
523.5(327) Bills of lading or freight receipts
523.6(327) Lease of equipment
523.7(327) Complaints
523.8(327) Tariffs

CHAPTER 524
Reserved

# CHAPTER 452
# FLASHING LIGHTS AND WARNING DEVICES ON SLOW-MOVING VEHICLES

[Appeared as Ch 3, Department of Public Safety, 1973 IDR]
[Prior to 6/3/87, Transportation Department[820]—(07,E) Ch 3]

**761—452.1(321) Slow-moving vehicle.** Slow-moving vehicle means any farm tractor, implement of husbandry, road construction or maintenance vehicle, road grader and any other vehicle principally designed for use off the highway which, when operated on the highway, is operated on the highway at a speed of 25 miles per hour or less.

This rule is intended to implement Iowa Code sections 321.383 and 321.423.

**761—452.2(321) Required equipment.** Slow-moving vehicles shall be equipped with and display at least one flashing light meeting the specifications of A.S.A.E. S279.4, and with a slow-moving vehicle warning device meeting the specification of A.S.A.E. S276.1.

452.2(1) *Lamps.*

*a.* There shall be at least one amber flashing warning lamp, conforming to SAE J974, Flashing Warning Lamp for Farm and Light Industrial Equipment, visible from both front and rear, and at least 42 inches (1067 mm) high as measured to the lamp axis. When more than one lamp is used, they shall flash in unison, be mounted at the same level and be as widely spaced as practicable.

*b.* The lamp shall comply in both the forward and rearward direction with the candlepower requirements of a Class "A" turn signal, SAE J575, Table 2. In addition, the lamp shall project at least 4 c.p. on both sides at 90° to the lamp axis.

*c.* The color of the light from the warning lamp shall be amber in accordance with SAE J578.

*d.* The lamp shall be flashed at least 60 f.p.m. (flashes per minute) but not more than 120 f.p.m. when it is operating.

*e.* The effective projected illuminated area measured on a plane at right angles to the axis of the lamp shall be not less than 12 square inches.

452.2(2) *Warning device.* The slow-moving vehicle warning device shall be mounted point up in a plane perpendicular to the direction of travel. It shall be placed at the rear of the vehicle, unobscured, and at least 2 feet above the ground measured from the lower edge of the emblem.

This rule is intended to implement Iowa Code sections 321.383 and 321.423.

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# CHAPTER 453
# WEIGHT EQUALIZING HITCH AND SWAY CONTROL DEVICES FOR TRAILERS

[Appeared as Ch 4, Department of Public Safety, 1973 IDR]
[Prior to 6/3/87, Transportation Department[820]—(07,E) Ch 4]

**761—453.1(321) Definitions.**

*Fifth wheel type connection.* A coupling between a trailer and the towing vehicle in which a portion of the weight of the trailer is carried on the towing vehicle of or forward of, the rear axle of the towing vehicle.

*Sway control device.* Equipment which is mounted on the trailer or a part of the hitch, used to limit sway from one side to another.

*Weight equalizing hitch or weight distributing hitch.* A mechanical device that connects the trailer to the towing vehicle and by means of leverage applied on both the trailer and towing vehicle structures or axles, distributes the imposed vehicle's load of the hitch and coupling connection between structures of towing vehicle and trailer when a towing vehicle frame is used, and between the rear axle of towing vehicle and the trailer structure when an axle mount is used. The towing vehicle thus loaded retains a level position with respect to the road.

This rule is intended to implement Iowa Code section 321.430.

**761—453.2(321) Weight equalizing hitches.** The following types of weight equalizing hitches are hereby approved for use with trailers:

**453.2(1)** Weight equalizing hitches which apply leverage by means of spring bars.

**453.2(2)** Weight equalizing hitches which apply leverage by means of coil springs.

**453.2(3)** Weight equalizing hitches which apply leverage by means of torsional bars.

This rule is intended to implement Iowa Code section 321.430.

**761—453.3(321) Sway control devices.** The following types of sway control devices are hereby approved for use with trailers:

**453.3(1)** Devices employing friction to limit sidesway.

**453.3(2)** Devices employing hydraulics to limit sidesway.

**453.3(3)** Devices employing torsional bars to limit sidesway.

**453.3(4)** Devices employing mechanical cams to limit sidesway.

**453.3(5)** Devices employing electronics to limit sidesway.

**453.3(6)** Fifth wheel types of connection.

This rule is intended to implement Iowa Code section 321.430.

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# CHAPTER 454
# TOWING WRECKED OR DISABLED VEHICLES

**761—454.1(321) Definitions.** For the purpose of Iowa Code section 321.463, the following definitions are established:

"*Tow*" means the transportation by a vehicle designed to tow wrecked or disabled vehicles directly from the scene of an accident, disablement, or impoundment to any place of repair, storage, or safekeeping.

1. The wrecked or disabled vehicle must be towed with all or some of its wheels on the roadway unless supported during movement by a dolly or other special device designed for use when a vehicle cannot roll on its own wheels.

2. Movement of wrecked or disabled vehicles on vans, flatbeds, carryalls, or other freight vehicles does not constitute towing under this rule.

"*Vehicle designed to tow*" means a vehicle that has been designed or materially altered to enable the transportation of a wrecked or disabled vehicle by lifting all or some of the wrecked or disabled vehicle off the roadway.

"*Wrecked or disabled vehicle*" means a vehicle upon a highway involved in an accident or having mechanical failure, broken parts, or other defects, any of which prevent the vehicle from moving safely under its own power, or any vehicle impounded by the order of a police authority.

This rule is intended to implement Iowa Code section 321.463.

[Filed 2/10/99, Notice 12/30/98—published 3/10/99, effective 4/14/99]

# CHAPTERS 455 to 479
Reserved

# CHAPTER 520
# REGULATIONS APPLICABLE TO CARRIERS
[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 8]

**761—520.1(321) Safety and hazardous materials regulations.**

**520.1(1)** *Regulations.*

*a. Motor carrier safety regulations.* The Iowa department of transportation adopts the Federal Motor Carrier Safety Regulations, 49 CFR Parts 390-399 (October 1, 1998).

*b. Hazardous materials regulations.* The Iowa department of transportation adopts the Federal Hazardous Materials Regulations, 49 CFR Parts 107, 171-173, 177, 178, and 180 (October 1, 1998).

*c. Effect of state law.* The Iowa department of transportation will follow and enforce the adopted federal regulations where not in conflict with state law.

*d. Obtaining copies of regulations.* Copies of the federal regulations may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402.

**520.1(2)** *Carriers subject to regulations.*

*a.* Operators of commercial vehicles, as defined in Iowa Code section 321.1 are subject to the federal regulations adopted in this rule unless exempted under Iowa Code section 321.449 or 321.450.

*b.* Rescinded IAB 9/16/92, effective 10/21/92.

**520.1(3)** *Declaration of knowledge of regulations.* Operators of commercial vehicles who are subject to the regulations adopted in this rule shall at the time of application for authority to operate in Iowa or upon receipt of their Iowa registration declare knowledge of the Federal Motor Carrier Safety Regulations and Federal Hazardous Materials Regulations adopted in this rule.

This rule is intended to implement Iowa Code sections 321.1, 321.449 and 321.450.

**761—520.2(321) Definitions.** The following definitions apply to the regulations adopted in rule 761—520.1(321):

*"Any requirements which impose any restrictions upon a person"* as used in Iowa Code section 321.449, unnumbered paragraph 8, means the requirements in 49 CFR Parts 391, 394 and 395.

*"Driver age qualifications"* as used in Iowa Code section 321.449, unnumbered paragraph 3, means the age qualifications in 49 CFR 391.11(b)(1).

*"Driver qualifications"* as used in Iowa Code section 321.449, unnumbered paragraph 2, means the driver qualifications in 49 CFR Part 391.

*"Farm customer"* as used in Iowa Code section 321.450, unnumbered paragraph 3, means a retail consumer residing on a farm or in a rural area or city with a population of 3000 or less.

*"Gasoline"* as used in Iowa Code section 321.450, first unnumbered paragraph, means leaded gasolines, no-lead gasolines, ethanol and ethanol-blended gasolines, aviation gasolines, number 1 and number 2 fuel oils, diesel fuels, aviation jet fuels and kerosene.

*"Hours of service"* as used in Iowa Code section 321.449, unnumbered paragraph 2, means the hours of service requirements in 49 CFR Part 395.

*"Record-keeping requirements"* as used in Iowa Code section 321.449, unnumbered paragraph 2, means the record-keeping requirements in 49 CFR Part 395.

*"Rules adopted under this section concerning physical and medical qualifications"* as used in Iowa Code section 321.449, unnumbered paragraphs 5, 6 and 7, and Iowa Code section 321.450, unnumbered paragraph 2, means the regulations in 49 CFR 391.11(b)(6) and 49 CFR Part 391, Subpart E.

*"Rules adopted under this section for a driver of a commercial vehicle"* as used in Iowa Code section 321.449, unnumbered paragraph 4, means the regulations in 49 CFR Parts 391 and 395.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

**761—520.3(321) Motor carrier safety regulations exemptions.**

**520.3(1)** The following intrastate vehicle operations are exempt from the motor carrier safety regulations concerning inspection in 49 CFR Part 396.17 as adopted in rule 761—520.1(321):

*a.* Implements of husbandry including nurse tanks as defined in Iowa Code section 321.1.

*b.* Special mobile equipment (SME) as defined in Iowa Code section 321.1.

*c.* Unregistered farm trailers as defined in 761—subrule 400.1(3), pursuant to Iowa Code section 321.123.

*d.* Motor vehicles registered for a gross weight of five tons or less when used by retail dealers or their employees to deliver hazardous materials, fertilizers, petroleum products and pesticides to farm customers provided the hazardous materials which are transported are clearly labeled.

**520.3(2)** Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.123, 321.449 and 321.450.

**761—520.4(321) Hazardous materials exemptions.** These exemptions apply to the regulations adopted in rule 761—520.1(321):

**520.4(1)** Pursuant to Iowa Code section 321.450, unnumbered paragraph 3, "retail dealers of fertilizers, petroleum products, and pesticides and their employees while delivering fertilizers, petroleum products and pesticides to farm customers within a 100-mile radius of their retail place of business" are exempt from 49 CFR 177.804; and, pursuant to Iowa Code section 321.449, unnumbered paragraph 4, they are exempt from 49 CFR Parts 391 and 395. However, pursuant to Iowa Code section 321.449, the retail dealers and their employees under the specified conditions are subject to the regulations in 49 CFR Parts 390, 392, 393, 394, 396 and 397.

**520.4(2)** Rescinded IAB 3/10/99, effective 4/14/99.

This rule is intended to implement Iowa Code section 321.450.

**761—520.5** Reserved.

**761—520.6(307,321) Out-of-service order.**

**520.6(1)** A person shall not operate a commercial vehicle or transport hazardous material in violation of an out-of-service order issued by an Iowa peace officer. An out-of-service order for noncompliance shall be issued when either the vehicle operator is not qualified to operate the vehicle or the vehicle is unsafe to be operated until necessary repairs are made. The out-of-service order shall be consistent with the North American Uniform Out-of-Service Criteria issued by the Federal Highway Administration, Office of Motor Carriers.

**520.6(2)** Notwithstanding Iowa Code sections 321.449 and 321.450, an operator of a commercial motor vehicle for which a commercial driver's license is required shall be subject to the 24-hour out-of-service provisions of Iowa Code section 321.208A.

This rule is intended to implement Iowa Code sections 307.12, 321.3, 321.208A, 321.449, and 321.450.

**761—520.7(321) Driver's statement.** A "driver" as used in Iowa Code section 321.449, unnumbered paragraph 5, and Iowa Code section 321.450, unnumbered paragraph 2, shall carry at all times a notarized statement of employment. The statement shall include the following:

1. The driver's name, address and social security number;
2. The name, address and telephone number of the driver's pre-July 29, 1996, employer;
3. A statement, signed by the pre-July 29, 1996, employer or the employer's authorized representative, that the driver was employed to operate a commercial vehicle only in Iowa; and
4. A statement showing the driver's physical or medical condition existed prior to July 29, 1996.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

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## CHAPTERS 521 and 522
Reserved

*Effective date of 520.1(1)"*a*" and "*b*"; rescission of 520.1(2)"*b*"; and 520.3 delayed until adjournment of the 1993 Regular Session of the General Assembly by the Administrative Rules Review Committee at its meeting held October 14, 1992; delay lifted by the Committee November 10, 1992.

*d.* An administrative appeal shall be deemed timely submitted if it is delivered to the director of the office of driver services or properly addressed and postmarked within ten days after receipt of the administrative law judge's decision.

*e.* The director of the office of driver services shall forward the appeal to the director of transportation. The director of transportation may affirm, modify or reverse the decision of the administrative law judge, or may remand the case to the administrative law judge.

*f.* Failure to timely appeal a decision shall be considered a failure to exhaust administrative remedies.

**620.4(3)** *Final agency action.* The decision of the director of transportation shall be the final decision of the department and shall constitute final agency action for purposes of judicial review. No further steps are necessary to exhaust administrative remedies.

**620.4(4)** *Petition to reopen a hearing.* Rescinded IAB 2/11/98, effective 3/18/98.

**620.4(5)** *Petition to reopen a hearing.*

*a.* A petition to reopen a hearing pursuant to Iowa Code section 17A.16 shall be submitted in writing to the director of the office of driver services at the address in 761—620.2(321J). If a petition is based on a court order, a copy of the court order shall be submitted with the petition. If a petition is based on new evidence, the petitioner shall submit a concise statement of the new evidence and the reason(s) for the unavailability of the evidence at the original hearing.

*b.* A petition to reopen a hearing may be submitted at any time even if a hearing to contest the revocation was not originally requested or held.

*c.* A person may appeal a denial of the petition to reopen. The appeal shall be deemed timely if it is delivered to the director of the office of driver services at the address in 761—620.2(321J) or properly addressed and postmarked within 20 days after issuance of the decision denying the petition to reopen.

**761—620.5(321J) Reinstatement.** When the revocation period has ended, a person shall be notified by the department to appear before a driver's license examiner to obtain a motor vehicle license. The license may be issued if the person has:

**620.5(1)** Filed proof of financial responsibility under Iowa Code chapter 321A for all motor vehicles to be operated.

**620.5(2)** Paid the $200 civil penalty.

**620.5(3)** Provided proof of satisfactory completion of a course for drinking drivers and proof of completion of substance abuse evaluation and treatment or rehabilitation services on a form and in a manner approved by the department.

**620.5(4)** Successfully completed the required driver license examination.

**620.5(5)** Paid the specified reinstatement fee.

**620.5(6)** Paid the appropriate license or permit fee.

**620.5(7)** Provided proof of deinstallation of the ignition interlock device if one was installed for a temporary restricted license.

**761—620.6(321J) Issuance of temporary restricted license after revocation period has expired.** The department may issue a temporary restricted license to a person whose period of revocation under Iowa Code chapter 321J has expired but who has not met all the requirements for license reinstatement. The period of issuance shall be determined by the department, but it shall not exceed six months from the end of the original revocation period.

**620.6(1)** An applicant for a temporary restricted license under this rule must meet one of the following two conditions:

*a.* The applicant must demonstrate to the satisfaction of the department that a course for drinking drivers was not readily available to the person during the revocation period and that the applicant has enrolled in a course for drinking drivers. The applicant must furnish the dates the class will begin and end.

*b.* The applicant must demonstrate to the satisfaction of the department that substance abuse evaluation and treatment or rehabilitation services have not been completed because of an inability to schedule them or because they are ongoing.

**620.6(2)** An applicant for a temporary restricted license under this rule must meet all other conditions for issuance of a temporary restricted license under rule 761—620.3(321J) and Iowa Code section 321J.20, including installation of an ignition interlock device.

**761—620.7** to **620.9** Reserved.

**761—620.10(321J) Revocation for deferred judgment.** The revocation period under Iowa Code subsection 321J.4(2) shall be 90 days.

**761—620.11** to **620.14** Reserved.

**761—620.15(321J) Substance abuse evaluation and treatment or rehabilitation services.** When the department revokes a person's license under Iowa Code chapter 321J, the department shall also order the person to submit to substance abuse evaluation and, if recommended, treatment or rehabilitation services. A provider of substance abuse evaluation and treatment or rehabilitation programs shall be licensed by the Iowa department of public health, division of substance abuse. A provider of a substance abuse evaluation who is not licensed by the Iowa department of public health may be granted provisional authority by the Iowa department of public health to conduct a substance abuse evaluation required under Iowa Code chapter 321J. To obtain provisional authority, the provider must apply for a license to the Iowa department of public health accompanied by a recommendation from the district court having jurisdiction for the offense. Provisional authority will expire on July 1, 1998.

**620.15(1)** *Reporting.*

*a.* A provider of a substance abuse program shall report to the department on a form and in a manner approved by the department when a person who has been ordered to attend the program has satisfactorily completed the program.

*b.* Reporting to the department shall be in accordance with Iowa Code sections 125.37, 125.84 and 125.86 and the federal confidentiality regulations, "Confidentiality of Alcohol and Drug Abuse Patient Records," 42 CFR Part 2, effective June 9, 1987.

**620.15(2)** *Payment.* Payment of substance abuse evaluation and treatment or rehabilitation costs shall be in accordance with Iowa department of public health rules.

**761—620.16(321J) Drinking drivers course.** When the department revokes a person's license under Iowa Code chapter 321J, the department shall order the person to enroll, attend and satisfactorily complete a course for drinking drivers, as provided in Iowa Code section 321J.22.

**620.16(1)** *Reporting.*

*a.* A community college conducting a drinking drivers course shall report to the department on a form and in a manner approved by the department when a person who has been ordered to attend the course has successfully completed it.

*b.* Reserved.

**620.16(2)** *Payment.* A person ordered to complete a drinking drivers course is responsible for payment of course fees and expenses in accordance with Iowa Code section 321J.22.

These rules are intended to implement Iowa Code chapters 17A and 321J and sections 321.376 and 707.6A.

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CHAPTERS 621 to 624
Reserved

**FIDUCIARY TAX**
*See TAXATION*

**FILMS**
Production
Marketing **261**—71.2(4)
Taxation exemptions
Income **701**—46.4(1,5)
Sales/rentals **701**—17.18

**FINANCE AUTHORITY, IOWA**
Board
Address **265**—1.3
Authority **265**—1.16
Title guaranty **265**—ch 9

Bonds
E 911 funding, taxation exemption **701**—40.39
Private activity, allocation **265**—ch 8
Revenue **265**—ch 4

Community builder program **261**—ch 80
Contested cases **265**—1.7, ch 7, 9.11, 9.22–9.30
Declaratory rulings **265**—1.6, 9.10
Disclosure
Reports, financial institutions **187**—16.10; **197**—ch 5; **265**—1.12
Title guaranty division **265**—9.15

Grants
Assistance fund **265**—ch 15
Shelters, homeless **265**—ch 14, 15.7(1)

Homesteading program **265**—1.8(10), ch 3
Housing credit, low-income **265**—ch 12
Loan programs
Assistance fund **265**—ch 15
Group homes **265**—ch 6
Mortgage/temporary **265**—ch 2
Revenue bond financing **265**—ch 4, 6.1
Small business **265**—ch 5

Mortgage credit certificates (MCC) **265**—ch 10
Organization **265**—ch 1
Records
  *Generally*, public/fair information **265**—ch 13
  Additions **265**—13.6
  Address **265**—13.3, 13.9
  Confidential **265**—13.4
  Definitions **265**—13.1
  Open **265**—13.4

Reports, mortgage disclosure, *see Disclosure above*
Rule making **265**—1.4, 1.5, 9.8, 9.9
Title guaranty division
  Board **265**—9.3–9.5
  Contested cases **265**—9.11, 9.22–9.30
  Declaratory rulings **265**—9.10
  Forms/manual **265**—9.7, 9.16
  Guaranty certificates **265**—9.12
  Participation requirements **265**—9.13–9.17
  Rates **265**—9.18
  Rule making **265**—9.8, 9.9
  Seal **265**—9.21

**FINGERPRINTS**
*Generally* **661**—11.4, 11.7, 11.8, 11.19

**FIRE AND FIRE PROTECTION**
Alarms **201**—50.9(8), 51.7(8); **661**—5.552(1)*a*, 5.610, 5.620(7), 5.802(4)*b*, 5.805(4)*b*, 16.705(12), *see also Health Care Facilities below; Schools/Colleges below*
Amusement parks **875**—62.8, 62.12
Apartments/rooming houses **661**—5.50–5.65, 5.100–5.105, 5.800–5.808
Arson
  Investigations **661**—5.6
  Investigators, retirement **581**—21.5(1)*a*(38)

Assisted living facilities **321**—27.9; **661**—5.626
Atriums **661**—5.801(9)
Birthing centers **661**—5.607–5.613
Buildings, *generally* **661**—ch 5, *see also specific buildings; BUILDINGS: Building Code*
Chemicals, hazardous **875**—110.2, ch 140

FIRE AND FIRE PROTECTION *(cont'd)*

Child care centers
*Generally* **441**—109.10(11,15); **661**—5.500–5.502
Day care, group **441**—110.9, 110.27(3)*b*(3), 110.27(4)*b*(3)
Exits **661**—5.500, 5.502(2)
Sprinklers **661**—5.500, 5.502(5)

Cities
Annexation/consolidation/incorporation **263**—2.3(9–13)
Inspections **481**—35.3(3), 35.10
Investigations **661**—5.6
Protection, water costs **199**—21.8

Colleges, *see Schools/Colleges below*
Companies, private, E 911 telephone service board **605**—10.3
Day care, *see Child Care Centers above*
Definitions **661**—5.2, 5.50(11), 5.230(1), 5.500, 5.550, 5.600, 5.607(7), 5.651, 5.800(5), 5.806
Dormitories, *see Schools/Colleges below*
Drills **441**—114.5(2); **661**—5.8, 5.502(6), 5.601(11)*b*, 5.613, 5.650(6)
Exits, *generally* **201**—50.9(7), 51.7(7); **661**—5.50, 5.52–5.65, 5.100–5.105, 5.607(10), 5.608, 5.620(2,12), 5.801, 5.804, *see also Child Care Centers above; Health Care Facilities below; Schools/Colleges below*
Explosives **567**—ch 131; **661**—5.7, 5.850, 5.851; **875**—140.1(4)
Extinguishers, *generally* **201**—50.9(5), 51.7(5); **281**—44.4(15), 44.6(2)*f*; **661**—5.40, 5.41, 5.230, 5.502(7), 5.601(9), 5.612(2), 5.620(8), 5.802(4)*d*, 5.805(5), 16.140(1)*p*; **875**—62.12, *see also Sprinklers below*
Fire escapes **661**—5.9, 5.101, 5.608
Firefighters
Benefits **545**—4.3; **581**—21.5(1)*a*(6,28), 21.6(9)*d*(4), 21.6(9)*e*, 21.13(6)*c*; **701**—40.4
Clothing/equipment **875**—ch 27
Motor vehicle registration plates **761**—401.9
Telecommunications network access **751**—7.6"14," 7.7(1)*n*
Training **567**—23.2(3)*g*; **641**—11.35(3)
Wages **875**—220.221-220.223, 220.225, 220.226

Fire marshal
*Generally* **201**—50.9; **661**—ch 5
Building approval **201**—50.9, 51.7; **661**—5.3, 5.5, 5.230(3), 5.607(10), 5.608(8)
Inspections, fire safety **661**—5.4, 5.5, 5.11, *see also Inspectors, Retirement below*
Investigations **661**—5.6, 5.12–5.14
Records **661**—5.10
Variances **661**—5.1(5)

Fireworks, parks **571**—ch 65
Flammable liquids
  *See also Explosives above*
  Amusement parks **875**—62.8, 62.12
  Bulk plants **661**—5.303
  Casualty losses, *see TAXATION: Motor Fuel subheads Credits; Refunds*
  Definition **875**—110.2
  Refrigerants **661**—5.252
  Service stations **661**—5.301, 5.304, 5.310
  Standards **661**—5.250, 5.300, 5.304, 5.350, 5.400, 5.450
  Storage facilities **661**—5.301, 5.802
  Tanks
    Aboveground **661**—5.300, 5.301(6), 5.305, 5.307
    Underground **567**—135.3(1)*a*(2), 135.3(1)*b*, 135.4(1,4); **591**—15.3(4); **661**—5.301(7), 5.311-5.313
    Vehicles, transport **661**—5.450
Foster care **441**—113.7, 114.5(2)
Gas
  Liquefied **661**—5.250–5.252, 5.275
  Turbine/combustion engines **661**—5.400
Halfway houses **643**—3.22(1), 3.23(9)*e*; **661**—5.607–5.613
Health care facilities
  *See also Assisted Living Facilities above; HEALTH CARE FACILITIES*
  *Generally* **661**—5.50–5.65
  Alarms **661**—5.552(8), 5.601(8), 5.602(10)
  Construction **661**—5.552, 5.601, 5.602
  Definitions **661**—5.550, 5.600
  Equipment, electrical/heating **661**—5.552(10), 5.601(10), 5.602(12,18)
  Evacuation **661**—5.552(11), 5.601(11), 5.602(13)
  Exits **661**—5.550(19–21), 5.552(3,4,13), 5.600(23–25), 5.601(3–6,13), 5.602(4–8,15)
  Extinguishers **661**—5.552(9), 5.601(9), 5.602(11)
  Furnishings **661**—5.552(14), 5.601(14), 5.602(16)
  Intermediate, mental illness **661**—5.603
  Locks **661**—5.552(3)*e*, 5.601(3)*e*, 5.602(4)*e*
  Nursing **661**—5.600–5.602
  Residential **661**—5.550, 5.552
  Smoking **661**—5.552(12), 5.601(12), 5.602(14)
  Sprinklers **661**—5.550(27,28), 5.552(7), 5.600(31,32), 5.601(7), 5.602(9)

High-rise buildings **661**—5.230
Hospitals, *see HOSPITALS*
Hotels **661**—5.50–5.65, 5.100–5.105, 5.230, 5.800–5.808, 16.705(12)*c*
Inspectors, retirement **581**—21.5(1)*a*, 21.5(1)*a*(40), 21.6(9)*d*(8), 24.27
Insulation, cellulose **661**—5.42
Insurance companies, information **661**—5.12–5.14
Investigations, *see Fire Marshal above*
Jails **201**—50.9
Juvenile detention facilities **661**—5.607–5.613
Licensure requirements
  *See also Child Care Centers above; Health Care Facilities above*
  Buildings, special functions **661**—5.5
  Explosives **661**—5.7
Migrant labor camps **641**—81.6
Occupancy **661**—5.51, 5.100(3), 5.501, 5.607(1,6,9), 5.620(13), 5.800(8,9), 5.801(9)*g*, 5.803, 5.809 Tables 8-A, 8-C
Oil wells/pipelines **565**—51.6(6), 51.11
Open burning **567**—20.3(2), 23.2, 27.3(3)*c*, 102.14(1)
Reports **661**—5.6(3,4)
Residential
  Apartments/dormitories/lodging/monasteries/convents **661**—5.800–5.809
  Group homes **441**—114.5(2); **661**—5.607–5.613, 5.620, 5.625
  Health care facilities **661**—5.550, 5.552
  Substance abuse facilities **643**—3.22(1), 3.23(9)*e*; **661**—5.607–5.613
Safety equipment
  *See also Alarms above; Smoke Detectors below; Sprinklers below*
  Boats **571**—37.1
  Fairs **371**—4.28(5)
Schools/colleges
  *Generally* **661**—5.50–5.65, 5.100–5.105, 5.650–5.667, 5.700–5.714, 5.750–5.765
  Alarms **661**—5.659, 5.706, 5.757
  Construction materials **661**—5.657, 5.658, 5.705
  Corridors **661**—5.701, 5.751, 5.762
  Doors **661**—5.654, 5.703, 5.752, 5.765
  Dormitories **661**—5.800–5.808
  Exits **661**—5.650–5.652, 5.654, 5.700, 5.711(5), 5.750, *see also Stairways this subheading below*
  Fire drills **661**—5.8, 5.650(6)

*FIRE AND FIRE PROTECTION (cont'd)*
*Schools/colleges*

Furnishings **661**—5.665, 5.712, 5.763
Heating/lighting systems **661**—5.707-5.709, 5.711(4), 5.758–5.760
Sprinklers **661**—5.653(2)*b*, 5.664, 5.666, 5.667(6), 5.713, 5.751(2)*b*, 5.764, 5.765(7)
Stairways **661**—5.656, 5.703, 5.714(2), 5.750(6), 5.754, 5.765(3)

Skywalks **661**—16.705(3)
Smoke detectors **661**—5.552(1)*a*, 5.610(4), 5.801(9)*b*, 5.802(4)*a*, 5.805(4)*a*, 5.806–5.809
Sprinklers **661**—5.52(6,7), 5.100(6), 5.601(7), 5.607(10), 5.608(2), 5.609(1), 5.610(1), 5.611, 5.802(4)*c,e*, 5.805(1), 5.805(4)*c*, 16.140(1)*g,s*, *see also Child Care Centers above; Health Care Facilities above; Schools/Colleges above*
Tanks, aboveground/underground, *see Flammable Liquids above*
Trucks
Certificates, emergency authorization **761**—451.2(2)
Registration **701**—34.5(10); **761**—400.5(1)*d*

**FIREARMS**
*See also HUNTING*
Buses, school **281**—43.38(2)
Collectors **661**—4.7–4.12
Corrections institutions, officers **201**—40.4(11,12)
Federal list **661**—4.8, 4.9
Hunting, *see HUNTING*
Paroled prisoners **205**—10.4(1)*h*, 11.5(1)*c*
Permits **661**—4.2, 4.4–4.6
Racetracks/riverboats **491**—9.4(13)*o*, 13.10(12), 25.15
Reserve officers certification **501**—ch 10
Seizure/disposition **61**—33.4(3); **661**—4.51–4.59
Shooting galleries/concession booths **875**—62.3(2)
Target shooting **571**—51.3
Training programs **501**—8.1(1), 8.4(2), 9.1(2), ch 10; **661**—4.1, 4.2(2), 4.3

**FISH AND FISHING**
*Generally* **571**—chs 81, 82
Bass **571**—81.1, 81.2(2), 81.2(6)*e*, 89.1
Bows and arrows/spears **571**—81.2(6)*f*
Buffalo **571**—82.2(1), 89.1
Carp **571**—81.2(6)*f*, 82.2(1), 89.1
Catfish **571**—81.1, 81.2(9), 82.2(1), 89.1
Commercial
Catch **571**—82.2(1,6)
Contracts/bids **571**—ch 82

Fuel set-aside **565**—3.13(2)*c*
Prohibitions **571**—84.1(2)
Taxation refund **701**—64.8, 64.11, 68.8(7)

Disease **571**—89.3
Dock management areas **571**—16.9
Drum **571**—82.2(1)
Endangered species **567**—72.2(7); **571**—77.4(5–7), ch 84
Frogs **571**—81.1
Gar **571**—81.2(6)*f*, 82.2(1), 89.1
Hatcheries, effluent/pretreatment standards **567**—62.4(42)
Ice shelters **571**—55.1
Importation, *see Permits: Importation below*
Length **571**—ch 81, 82.2(2)
Licenses
Applications **571**—15.2(2)
Commercial fishing **571**—ch 82
Definitions **571**—15.1(1)
Depositaries **571**—15.2, 15.3
Disabled **571**—15.7, 15.8
Exemption, substance abuse patients **571**—15.4
Low-income, elderly/disabled **571**—15.8
Revocation/suspension **571**—15.6
Sales **571**—15.2
Scuba/skin spearing **571**—83.2(6)

Limits, daily **571**—ch 81
Motor vehicle restrictions **571**—ch 49
Mussels **571**—ch 87
Natural resources
Authority **561**—1.1, 1.2(4), 1.3(2)*i*; **567**—61.2(2)*g*, 70.5(3)*c*
Offices, district **561**—1.4(5–7)
Officials, financial disclosure **351**—11.2"24"

Offenses **571**—15.6(3)
Paddlefish **571**—81.1, 81.2(4)
Parks/recreation areas **571**—61.5(14), 61.21–61.24
Perch **571**—81.1, 81.2(6)*e*, 89.1
Permits
Exemption, substance abuse patients **571**—15.4
Importation **571**—77.4(5,6), 89.2, 89.3

Scientific collection **571**—77.4(7)
Tournaments **571**—88.2, 88.4

Pet food ingredients, labels **21**—42.3(5,6)
Pet shops **21**—67.1, 67.4(4)
Pike **571**—81.1, 81.2(1,6), 89.1
Processing, investments, taxation credit **701**—42.10, 52.9
Salvage **571**—77.4(7), chs 80, 111
Scuba/skin spearing **571**—ch 83
Seafood **481**—31.1(6); **567**—62.4(8)
Seasons **571**—81.1, 81.2(1)
Seizure/impoundment **21**—67.4(4)
Stamp designs **571**—ch 9
Standards, organic production **21**—47.3, 47.4"9"
Sturgeon **571**—81.1, 82.2(1), 89.1
Sucker **571**—81.2(6)*f*, 82.2(1), 89.1
Sunfish **571**—81.2(6)*e*, 89.1
Taxation **701**—17.9(1), 39.2, 40.28(1), 40.38(2), 42.10(1)*c*, 43.4(1), 47.1(3), 47.2(1)*b*, 49.1(4), 49.2(1)*b*, 49.6, 52.9, 53.8, 64.8, 64.11, 68.8(7)
Tournaments **571**—ch 88
Trotlines **571**—ch 85
Trout **571**—chs 9, 49, 81.1, 81.2(5), 89.1
Turtles **571**—ch 86
Walleye **571**—81.1, 81.2(1,3,6), 89.1
Water quality **567**—43.5(1)*b*(4), 61.2(1), 61.2(2)*g*, 61.2(4)*i*, 61.2(5)*a*, 61.3(1)*b*(5), 61.3(3)*b*, 61.3(3) Table 1, 70.5(3)*c*, 72.2(7), 72.9(4)

**FITNESS CENTERS**
*See CLUBS, PRIVATE*

**FLOOD CONTROL**
Boat docks **567**—71.10
Bridges/culverts/crossings/embankments **567**—71.1, 72.1
Buildings, approval **261**—24.11(7); **567**—71.7, 72.5, 75.5
Channel changes **567**—70.5(3)*c*, 71.1(1), 71.2, 72.1(4), 72.2, 72.31
Dams **567**—70.2, 71.3, 72.3, ch 73, 151.2, *see also DAMS*
Definitions **567**—70.2, 100.2
Disasters
Fuel loss, taxation refund **701**—68.8(14)
Price gouging **61**—ch 31
Recovery funds **27**—ch 15; **261**—23.13; **427**—ch 24; **441**—153.8

*FLOOD CONTROL (cont'd)*
*Disasters*


Taxation
Construction **701**—19.13(2)*i*
Fuel loss, refund **701**—68.8(14)
Records, loss **701**—10.8(1)*e*, 15.3(2)*c*

Emergencies, repair **567**—72.1(8)
Excavations **567**—71.11, 72.11(2)
Flood plains
Projects
Appeals **567**—70.6
Approval, requirements **567**—chs 70–72
Bonds **567**—72.30(6)
Forms **567**—70.3
Maintenance **567**—72.30
Management **561**—1.2(5), 1.3(2)*h*; **567**—ch 75
Permits **561**—1.2(5), 1.3(2)*h*(1)"4," 2.14(1)*f*; **567**—61.2(2)*h*, 70.4, 70.5, 72.3(2)*c*, 72.30(3), 121.3(3)
Standards **567**—75.2, 75.5
Variances **567**—72.31, 75.8

Property sales, disclosure **193E**—1.39(6)"14"
Streams, protected, *see Streams, Protected below*
Wastes
Lagoons/basins, construction **567**—65.15(10)
Land application restrictions **567**—65.2(11)*d*, 67.8(2)*j*, 68.9(1)*c*(2)"7," 101.3(1)*c*, 121.3(3), 121.4(1)*a*(10,17)

Floodways **567**—75.4
Grants, *see Disasters: Recovery Funds above*
Insurance
Homeless shelters **261**—24.11(7)
Lenders, real estate **187**—9.2(6); **189**—9.2(7)

Landfills **567**—71.6, 72.7
Levees/dikes **27**—ch 14; **567**—70.2, 71.4, 72.4, 72.11(2)*b*
Miscellaneous structures **567**—71.12, 72.11(1)
Natural resources department authority **561**—1.2(5), 1.3(2)*h*
Pipeline crossings **567**—71.8, 72.10
Quarries **567**—50.6(3), 72.11(2)*c*
Shelters, emergency, insurance **261**—24.11(7)
Soil/water conservation practices, repair loan **27**—ch 15

Streams, protected **567**—71.9, 72.2, 72.9, 72.31(3), 72.32, 72.50–72.52
Violations, penalty **567**—10.2(4), 75.7(4)
Wastewater treatment facilities **567**—71.5, 72.6
Water resource projects **567**—ch 76
Water treatment facilities **567**—71.5, 72.8
Wells **567**—49.6

**FLORISTS**
Taxation **701**—18.10, *see also NURSERIES, HORTICULTURAL*

**FOOD**
*See also HEALTH CARE FACILITIES; HOSPITALS*
Adulteration **481**—31.6
Apple grading **21**—ch 11
Bed/breakfast facilities **481**—30.2
Butter **21**—71.6
Caterers **401**—14.7(6); **441**—114.4(5); **701**—20.5
Child care centers **441**—109.15
Commodities **21**—20.4, 71.3; **281**—5.15(12); **321**—5.7(4), 7.3(18); **441**—ch 73
Concessions **371**—4.24, 4.28, 7.2(3), 7.4(1), 7.5(1), 7.16(2), 7.17(2); **561**—ch 14; **571**—ch 14
Congregate/home-delivered meals **321**—5.6, 6.8"19,20," 7.3; **441**—77.33(8), 77.34(6), 78.37(8), 78.38(6), 79.1(2), 83.26
Dairy products **21**—1.5(9), 1.6(3), chs 23, 68, 71, *see also DAIRIES*
Definitions **441**—73.1; **481**—30.2
Disasters, community **321**—7.3(9)*b*(6,8), 7.3(11)*b*; **441**—73.61
Education, curricula/programs **281**—12.5(3)*e*, 12.5(4)*e*, 12.5(5)*e*, 12.5(5)*i*(2,5), 31.4, 33.11, 68.8; **282**—16.1(1)*d*
Eggs, *see EGGS*
Establishments
  Definitions **481**—30.2
  Home **481**—30.2, 30.4(4), 30.8(4), 31.1(2), ch 34
  Inspection **321**—27.10(3); **481**—1.5, 30.1, 30.8, 30.10, chs 31, 34, 35
  License **201**—50.16(8); **321**—27.10(3); **481**—30.2–30.7, 30.12, 31.8, 31.11, 34.2, 34.5
  Restrooms **481**—31.9(1)
  Sales, documentation **481**—30.3(5), 34.4
  Sanitation **481**—31.1, 31.7(6), 34.1
  Sinks **481**—31.1(8,9,12)
  Violations/penalties **481**—30.5, 31.8, 31.11

*FOOD (cont'd)*

Farmers markets **21**—ch 50; **481**—30.2; **701**—18.9
Food stamps **321**—6.4(2)*w*, 7.3(19); **441**—7.7, 7.9, 7.21, 11.3, 11.5, ch 65, 73.47(3), 76.8, 93.105(2); **481**—1.6"1," 5.11(3), 5.12(2), 71.5, 71.6(2), chs 72, 74; **701**—20.1-20.4, 20.5(1)*b*, 43.3(3); **877**—8.4(8), 8.12, *see also HUMAN SERVICES DEPARTMENT*
Illness, food-borne **481**—35.5; **641**—1.2(1,2)
Institutions
  Child care, federal program **281**—5.15(16)
  Commodity programs **441**—73.2, 73.3(3), 73.8, 73.41-73.62
Jails **201**—50.16, 50.17
Labels **21**—47.1, 47.2, 47.8, 59.1, 71.2, 71.5; **481**—30.14, 31.5, 34.3, 36.8; **641**—13.1; **875**—110.1(5), *see also Pet below*
Laboratory, state **21**—1.5(9)
Livestock, *see FEED, COMMERCIAL; MEAT*
Meat, *see MEAT*
Migrant labor camps **641**—81.5
Milk, *see DAIRIES*
Mobile units/pushcarts **481**—30.2, 30.3(4), 30.4(6), 31.7
Organic, production/distribution **21**—ch 47
Packaging, oxygen **481**—31.1(5)
Pesticides
  EDB (ethylene dibromide) **21**—45.45
  Food processors/distributors, application **21**—45.22(14)
Pet **21**—ch 42, 76.7, 76.8(2), 76.10(2), 76.11(2)
Poisoning, reports **641**—1.2(1,2)
Processing plants **21**—45.22(14); **481**—30.2, 30.4(8), 30.5, 30.7(6), 30.8(2), ch 31
Production, radioactive control devices **641**—39.4(22)*d*(2)
Retailers, *see Establishments above*
Salvage **481**—30.2, 30.9
School lunch program **281**—5.15(11), ch 58; **701**—17.11
Seafood **481**—31.1(6); **567**—62.4(8)
Service establishments
  Advertising, signs **761**—ch 118
  Congregate **321**—7.3(9)*b*(5)
  Definitions **481**—30.2
  Fire safety **661**—5.50-5.65, 5.100-5.105, *see also FIRE AND FIRE PROTECTION: Fire Marshal*
  Home delivery, medical assistance **441**—77.34(6), 78.37(8)

*FOOD (cont'd)*
*Service establishments*

Hotels **481**—30.4(5), 30.8(3)
Inspection **481**—30.1, 30.8–30.10, ch 35
Institutions, charitable **441**—73.52
Licenses **321**—7.3(9)*b*(5); **481**—30.2–30.7, 30.12
Mass gatherings **641**—19.4(6)
Restrooms **481**—31.9(2); **641**—19.4(3)*f*; **661**—16.401
Sanitation
Bars **481**—31.10
Employee requirements **481**—31.1(3)
Jails **201**—50.16(8), 50.17(4)
Sinks **481**—31.7(6), 31.10
Taxation, employee tips **701**—18.26, 40.49
Temporary **481**—30.2, 30.4(7), 30.7(5)
Violations/penalties **481**—31.8, 31.11

Soup kitchens **441**—73.21–73.30
Stamps, *see Food Stamps above*
Standards
Area agencies on aging (AAA) **321**—7.3(7,8,15)
Commodity sales **21**—71.3
Dairy products **21**—chs 68, 71; **567**—62.4(5); **641**—13.1
Disposal, *see Salvage, Disposal this subheading below*
Inspections, establishments/service establishments **481**—chs 31, 34, 35
Meat **21**—47.3(1–3), ch 76; **567**—62.4(32)
Organic **21**—ch 47
Packaging/labeling **21**—71.2; **481**—31.1(5), 31.5; **641**—13.1
Processing, effluents **567**—62.4(5–9,32)
Salvage, disposal **481**—30.9
Sorghum **21**—59.1(2)
Vendors **481**—47.6(4), 47.7
Wholesale **481**—31.2, 47.7(3)

Supplemental program, women/infants/children (WIC) **21**—ch 50; **641**—ch 73, *see also PUBLIC HEALTH DEPARTMENT*
Surplus program **441**—73.1–73.15
Taxation
Concessions **701**—17.1(5), 18.39
Exemptions, Iowa grown **701**—17.32
Food stamp purchases **701**—20.1–20.4, 20.5(1)*b*
Meals **701**—16.13, 17.11, 18.5(2), 18.15, 18.26, 20.5

*FOOD (cont'd)*
*Taxation*

Meal tickets **701**—16.23
Processing **701**—17.2, 17.3(2,3), 18.29(6)
Produce sales, farmers **701**—18.9
Schools, lunches **701**—17.11
Service charges **701**—18.26
Sororities/fraternities **701**—18.15
Vending machines **701**—12.8, 13.14, 17.11"B," 20.5(2), 20.6

Vendors
Blind commission, operators **111**—ch 7, *see also BLIND, DEPARTMENT FOR: Commission*
Farmers markets **21**—50.4, 50.9–50.13; **481**—30.2
Machines, inspection/licensure **481**—1.5, 30.1, 30.2, 30.3(3,4), 30.4(3), 30.8(4), ch 35
Organic **21**—47.6(4,5), 47.7
Sales tax, *see Taxation above*
WIC (women/infants/children) program **21**—ch 50; **641**—ch 73

**FORECLOSURE**
Employers, unemployment contributions/charges **871**—23.28(7)*e*, 23.65(4)
Grants, homeless **427**—23.5(6)
Livestock sales **21**—64.15
Loans **25**—2.5(4), 4.9(6,8); **27**—11.21(2)*f*; **265**—2.7
Motor vehicle sales, titles **761**—400.4(6)
Property sales, taxation **701**—18.4, 40.27

**FORESTS**
Administrator, state division **571**—72.2(2)
Camping **571**—ch 62
Conservation practices, water protection **27**—12.80–12.84
Grants, community forestry challenge **571**—ch 34
Keg beer parties **571**—ch 63
Natural resources authority **561**—1.1, 1.2(6), 1.3(2)*e,f*; **571**—54.4
Nursery stock **571**—ch 71
Real estate assessment **701**—80.9
Reservations **571**—chs 32, 73; **701**—80.9
Timber cutting, *see TIMBER*
Trails, recreation **571**—ch 67
Wild turkey hunting **571**—98.2(3), 98.11, 99.2

**FORFEITURE**
*See also PROPERTY; REAL ESTATE*
Bond, *see BONDS*
Jockeys **491**—10.4(2)*m*

**FOSTER CARE**
*See also ADOPTION*
Child abuse **441**—108.8(1)*c*(13), 112.5(1)*d*, 112.6(1), 112.10, 113.13, 114.7(3), 114.8(1), 114.19, 117.7(2)*a*, 202.13
Complaints, investigation **441**—108.8(5)
Definitions **441**—112.2, 113.2, 114.2, 115.2, 116.2, 156.1, 164.1, 202.1
Drugs **441**—114.12, 115.10, 156.8(3)
Education **281**—41.132(5), 64.8"5," 65.5"5"
Eligibility/need information **441**—9.10(4)*c*, 9.10(13), 202.2, *see also Payment below*
Family homes **441**—chs 112, 113
Food stamp eligibility **441**—65.24
Grants, *see Payment below*
Group living **265**—ch 6; **441**—65.9, chs 112, 114, 156.10, 202.8, 202.17; **661**—5.607–5.613, *see also Services: Treatment, Family/Group below*
Hearings/appeals **481**—1.6"1"
HIV infections **441**—113.10(1)*d*, 202.6(1), 202.10(4)
Hospitalization **441**—156.10(1)*b*, 156.10(2)*b*
Inspections **481**—1.5, 5.12(2)"3," ch 40, 108.8(4)
Insurance **441**—ch 158
Licensing, *generally* **441**—108.8(1–3), chs 112–116; **481**—1.5"5," ch 40
Loans, Iowa finance authority **265**—ch 6
Medical assistance **441**—75.1(10), 75.16(1)*f*, 76.1, 76.2(1)*a*(1), 76.7, 77.30(5)*d*, 79.1(2) p.8, *see also HUMAN SERVICES DEPARTMENT: Medical Assistance (Medicaid): Rehabilitation: Treatment Service Providers*
Mentally retarded **441**—chs 112, 116, 202.2(5)
Parents
  Foster **441**—108.8(6), 113.3, 113.4, 113.8, 113.9, 113.11–113.14, chs 117, 156, 185.10(8)*b*(2,5,6), 185.105(12), 200.3(1)*a*, 202.10
  Leaves, employment **581**—14.4
  Natural **441**—113.9, 202.1, 202.12
  Reunification services **441**—ch 182
Payment
  *See also Medical Assistance above*
  Adoptive homes **441**—156.17

*FOSTER CARE (cont'd)*
*Payment*

Amount **441**—150.3(6)*b*, 156.5–156.9, 156.12, 156.19, 156.20(1)*b*(3)"4," 156.20(1)*c*
Child's income **441**—156.15, 156.16
Claims, insurance **441**—ch 158
Clothing allowance **441**—156.8(1)
Definitions **441**—156.1
Eligibility
  Client **441**—156.20(1)
  Provider **441**—156.20(2)
Emergency care **441**—156.8(3), 156.11
Family care **441**—156.6, 156.10(2)
Funeral expense **441**—156.8(5)
Grants **441**—153.5(2)*b*, ch 164
Independent living **441**—156.8(2), 156.12, 156.20(1)*b*, 202.9
Medical care **441**—75.1(10), 156.8(3,4)
Out-of-state **441**—156.9(2)
Parent liability **441**—156.1, 156.2
Rate, *see Amount this subheading above*
Recovery **441**—156.2; **701**—43.3(3,5), 43.4(2), 150.2(2), 150.6
Rehabilitative treatment **441**—156.7(3), 185.102(2)*e*, 185.105, 185.106(4), *see also HUMAN SERVICES DEPARTMENT: Rehabilitative Treatment/Supportive Services: Providers*
Reimbursement **441**—156.7, 156.9, 185.103(7), 185.106(4)
Reserved beds **441**—156.10
Special needs child **441**—156.1, 156.6(4), 156.8(7)
Training **441**—156.18
Trust funds **441**—156.16

Placement
Agencies **441**—chs 108, 117; **489**—2.3
Agreement **441**—108.8(7), 113.10(1)*f*
Case permanency plan **441**—202.6, 202.15
Committees, review **441**—202.2(5), 202.6(5)
Discharges, *see Termination below*
Eligibility **441**—202.2
Group **441**—202.8(2), 202.17, *see also Group Living above*
Independent living **441**—156.8(2), 202.9, *see also Payment above*
Interstate **441**—ch 142, 156.9(2), 156.20(1)*a*(2), 202.8
Notification, parent **441**—202.12(2)
Out-of-region **441**—202.7

Out-of-state **441**—202.8
Preplacement **441**—113.8(2), 117.2, 202.2(5), 202.5, 202.6(3)
Prevention **441**—chs 179, 185 Div. III, *see also Services: Family-Centered below*
Records/information **441**—113.10
Regional, group care target **441**—202.17
Selection **441**—202.4
Voluntary **441**—156.2(2), 156.14, 202.3

Rehabilitative treatment, *see Services below*
Residential facilities **441**—chs 114–116, 156.19, 185.10(8)*c*, ch 185 Div. V, 185.106(2)*a*, 185.107(4); **661**—5.607-5.613; **701**—17.19(2)*b*
Respite care **441**—156.8(7), ch 180
Review boards
Definitions **489**—1.1(2)
Local
Child eligibility **489**—3.6
Coordinator **489**—3.5
Duties **489**—1.1, 3.1, 3.4
Membership **489**—3.2, 3.3

Records
*Generally,* public/fair information **161**—ch 4
Address **489**—4.3
Confidential **489**—2.5, 4.11, 4.12, 4.13(2)
Definitions **489**—4.1, 4.10
Disclosures **489**—4.9–4.11
Open **489**—4.13(1)
Personally identifiable information **489**—4.14

State
Address **489**—1.1(1)
Appointment **481**—1.9
Director **489**—2.2
Duties **481**—1.9; **489**—1.1, 2.1(4)
Registry **489**—2.3

Training **489**—2.4

Services
*See also Respite Care above*
Behavioral management **441**—156.6(4)*d,e*, 185.1, 185.10(1)*a*(1,5), 185.10(8)*b*(2), 185.61, 185.62(3)*a*, 185.105(1)*f*

*FOSTER CARE (cont'd)*
*Services*

Contracts **441**—ch 152, 156.7
Emergency assistance **441**—133.3(4), *see also Payment above*
Family-centered **441**—ch 182, 185.3(5)*a*(3), ch 185 Div. II, 185.102(2)e, 185.105, 185.106(4)
Placement, *see Placement above*
Rates, *see Payment above*
Support **441**—202.10–202.12
Treatment, rehabilitative, family/group **441**—185.3(5)*a*(3), 185.10(8)*b*, ch 185 Div. IV, V, 185.102, 185.105, 185.106(4), *see also Behavioral Management this subheading above; Payment above*

Support recovery benefits **441**—99.4, 99.5(4)
Termination **441**—202.13, 202.14
Therapeutic, *see Services: Behavioral Management above*
Training **441**—108.8(6), 113.8, chs 117, 156, 185.10(8)*b*(2,7), 185.105(12), *see also Review Boards above*
Visitation, service worker **441**—113.15, 202.10(3), 202.11

**FOUNDLINGS**
*See BIRTH*

**FRANCHISES**
*See also TAXATION*
Electric utilities
Advertising, expense accounts **199**—16.2(8) section 913.5
Transmission lines **199**—2.4, ch 11

Motor vehicle **761**—425.10(3), 425.50

**FREEWAYS**
*See HIGHWAYS*

**FREIGHT**
*See ELEVATORS; TRANSPORTATION DEPARTMENT*

**FRUIT-TREE RESERVATIONS**
*See PLANTS: Trees*

**FUEL**

Accident reports, supply lines **199**—10.17
Additives
  Advertising **21**—85.48(10–15)
  Consumer information **567**—144.3
Advertising **21**—85.48; **701**—64.21
Aircraft **661**—5.304(2), *see also TAXATION: Motor Fuel*
Alcohol **185**—4.30
Bulk plants, *see Storage below*
Carriers
  *See also CARRIERS*
  Interstate/intrastate, permits **761**—ch 505
  Transport, liquid **661**—5.450; **701**—64.19; **761**—chs 520, 528, 607.17(3)
Decals, renewable **21**—12.4, 85.48(10)
Definitions **21**—85.48(15); **701**—63.1; **761**—400.1(14), 505.1
Electric utilities, costs **199**—20.9
Emissions **567**—23.3(2)*b,d*, 23.3(3)
Ethanol
  Production **21**—ch 12; **261**—57.4(3)
  Taxation, *see TAXATION: Motor Fuel*
Farm use, *see AGRICULTURE*
Filling stations, *see Service Stations below*
Funds, tire-derived fuel **567**—ch 216
Gas, *see GAS*
Gas utilities, *see GAS UTILITIES*
Kerosene **701**—67.1
Leaded **21**—85.48(15)
Meters, *see Pumps/Meters below*
Permits, interstate motor vehicle **761**—ch 505
Petroleum, *see PETROLEUM*
Pipelines **199**—chs 9, 10
Pollutants, standards **567**—23.1(2)*g*, 23.1(2)*pp*, 23.3(2)*d*, 23.3(3)
Price posting **21**—85.48; **701**—64.21
Pumps/meters **21**—1.2(1)*c*, 85.34–85.46, 85.48, 85.49, *see also TAXATION: Motor Fuel*
Regents institutions **567**—ch 216
Renewable
  Production assistance **21**—ch 12; **261**—ch 57
  Pumps, decals **21**—12.4, 85.48(10)

*FUEL (cont'd)*

Safety **661**—5.4(3), 5.11(2), 5.250, 5.251, 5.275, 5.300, 5.301, 5.303–5.305, 5.307, 5.310–5.313, 5.450; **875**—62.8
Service stations
 Meters, *see Pumps/Meters above*
 Methyl tertiary butyl ether **21**—85.48(11)
 Price posting, *see Price Posting above*
 Safety **661**—5.301, 5.304, 5.310
 Self-service **661**—5.310(3)
 Service pits **661**—5.304(2)
 Storage tanks, *see Storage below*
Special fuel **701**—chs 63–65, 67–69, 107.9"2"; **761**—400.1(14), 400.53(2), 505.1, *see also TAXATION: Motor Fuel*
Standards **21**—85.33; **567**—23.3(2)*b*, 23.4
Storage
 Bulk **567**—23.1(2)*pp*; **591**—5.3; **661**—5.301, 5.303; **701**—64.21(3); **875**—62.8
 Farms **661**—5.305
 Liquefied natural gas **661**—5.275
 Liquefied petroleum **567**—23.1(2)*bb,cc*; **661**—5.250, 5.251; **875**—62.8
 Refuse-derived **567**—104.10(5)
 Tanks
  Aboveground **591**—6.1; **661**—5.300, 5.301(6), 5.307
  Underground **199**—ch 10; **567**—chs 135, 136; **591**—chs 5, 6, 10–13, 15; **661**—5.301(1,7), 5.311-5.313; **701**—ch 37, *see also ENVIRONMENTAL PROTECTION COMMISSION; PETROLEUM*
 Terminals
  Emission standards **567**—23.1(2)*pp*, 23.1(4)*r*
  Meters **701**—68.14
  Records **701**—68.15
Tanks, *see Storage above*
Taxation
 Excise **701**—15.12(2)*c*
 Motor/special **701**—chs 63–65, 67–69, 89.8(11)*c*, 107.9"2," *see also TAXATION: Motor Fuel*
 Permits, interstate motor vehicle **761**—ch 505
 Sales **701**—15.3, 17.2, 17.3, 17.9(4,5), 17.13, 18.2, 18.37, 18.38, 18.58
Transportation, *see Carriers above*

**FUNERALS**
*See also BURIAL; CEMETERIES; DEATH*
Advertising **645**—101.212(1)*g*
Burial benefits **441**—ch 56
Children, adopted/foster **441**—156.8(5), 201.6(1)*a*(8)
Costs **645**—101.7
Cremation, establishments/requirements **641**—ch 86, 101.6(3), 127.3; **645**—100.1, 100.5(1)*b*, 100.5(4), 100.9, 100.11, 101.200, 101.213, 101.214
Definitions **191**—15.2; **641**—86.2; **645**—100.1, 101.100, 101.200
Directors
  Arrangements **645**—100.6
  Bodies
    Preparation **641**—86.5; **645**—100.3(2), *see also Embalming this subheading below*
    Removal **481**—51.24(4); **641**—100.3, 101.6
    Shipment **645**—100.7(5), *see also Burial Transit Permits this subheading below*
    Unclaimed **645**—100.7
  Burial transit permits **641**—101.5, 101.6, 101.8, 127.2, 127.3; **645**—100.4, 100.11(6)*a*
  Cause of death **641**—101.8
  Child support noncompliance **641**—ch 192; **645**—ch 115
  Claims, expense, foster/adopted child **441**—156.8(5), 201.6(1)*a*(8)
  Communicable diseases **481**—51.24(4), 57.11(10), 58.10(11), 59.12(10), 63.9(12); **641**—101.5(5); **645**—100.1, 100.3(2), 100.5(1,2,4)
  Complaints **645**—101.201–101.203
  Continuing education
    Approvals **645**—101.100, 101.102, 101.103
    License reinstatement/renewal **645**—101.2(12–14), 101.4(7), 101.5, 101.101, 101.109(2)*c*
    Reports **645**—101.105, 101.106, 101.212(10)
    Sponsors **645**—101.100, 101.103, 101.106
    Waivers **645**—101.107–101.109
  Death certificates **641**—98.2, 99.12(2), 101.3, 101.8, 102.1(2), 103.1(1)*b*, 127.2
  Disinterment **641**—101.7, 173.1(2); **645**—100.1, 100.8
  Education **645**—101.1(3), 101.3
  Embalming **641**—ch 86; **645**—100.3(1)*c,d*, 100.5, 101.212(14)
  Impairment, practitioners **641**—ch 193; **645**—ch 114
  Inspections **641**—86.7
  Internship **645**—101.3(1)

*FUNERALS (cont'd)*
*Directors*

Licenses
Address change **645**—101.212(9)
Application **645**—100.9(3), 101.2
Denial **641**—192.1; **645**—101.205
Endorsement **645**—101.4
Establishments **641**—86.3; **645**—100.9, 101.98(13–15)
Examinations **645**—101.2(5,10), 101.4(2,4), 101.5(1)*e*, 101.109(2)
Fees **641**—192.2(5); **645**—100.9(3), 100.10, 101.2(14), 101.98
Inactive practitioner **645**—101.6, 101.108, 101.109
Out-of-state **645**—101.4
Reinstatement **645**—100.10(3), 101.2(14), 101.5, 101.6, 101.109
Renewal **641**—192.1; **645**—100.10, 101.2(12–15), 101.4(7), 101.101
Revocation/suspension **641**—192.2; **645**—101.212, ch 115

Malpractice, *see Mortuary Science Examiners Board: Discipline below*
Military interment, graves, registration **801**—1.7
Peer review **645**—101.215
Preceptorship **645**—101.3(2)
Registrar listing **641**—ch 98
Taxation **701**—18.21

Leave, attendance **581**—14.3(11); **681**—3.148
Mortuary science examiners board
Appeals **645**—101.209
Complaints **645**—101.201–101.203
Declaratory rulings **645**—ch 102
Discipline **645**—101.200–101.209, 101.211–101.215
Hearings **645**—101.104, 101.204–101.208
Impaired practitioner review committee **641**—ch 193; **645**—ch 114
Licenses **641**—170.4(1), *see also Directors above*
Meetings **645**—101.300
Records **645**—ch 109
Registration **645**—101.1
Rule making **645**—chs 103, 104

Permits, *see Directors: Burial Transit Permits above*
Prearrangement **191**—15.2, 15.6, ch 19
Taxation **701**—18.21

**FURS**
*See ANIMALS; HUNTING*