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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.

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CHAPTER 14
EXECUTIVE CLEMENCY
[615—Ch 14 transferred to 205—Ch 5, IAB 2/22/89]

205—14.1(902) Interviews of inmates serving life terms. The board shall not grant a parole or work release to a Class "A" felon serving a life term unless the governor commutes the sentence to a term of years. Administrative rules relating to the parole and work release consideration of an inmate sentenced to an indeterminate term shall not apply to an inmate sentenced to a life term. The board shall interview a Class "A" felon serving a life term to determine whether to recommend that the governor commute the sentence to a term of years. The board shall recommend that the governor commute the sentence when the board concludes that the inmate should be considered for release on parole or work release. In making such a recommendation, the board shall also indicate the existence of any registered victims, and communicate any opinions expressed by those victims regarding release of the inmate.

205—14.2(902) Review of inmates serving life terms. Rescinded IAB 6/28/00, effective 6/8/00.

205—14.3(248A) Executive clemency applications.

14.3(1) *Applications to the board.*

a. A person convicted of a criminal offense may apply to the board for a recommendation to the governor for a reprieve, pardon, commutation of sentence, or remission of fines and forfeitures at any time following the person's conviction.

b. An application for a pardon or commutation of sentence shall be on the form provided by the board. The form may be obtained by contacting the board business office.

c. An application for a reprieve or remission of fines and forfeitures shall be in writing.

d. The applicant shall submit the executive clemency application to the board business office.

14.3(2) *Applications to the governor.* Upon the request of the governor, the board shall take charge of all correspondence in reference to an executive clemency application filed with the governor and shall provide the governor with the board's advice and recommendation.

14.3(3) *Restoration of citizenship.*

a. A person convicted of a criminal offense may apply for a restoration of citizenship at any time following the discharge of the person's sentence.

b. A person applying for restoration of citizenship within 60 days of discharge of the person's sentence shall submit the short form Application for Restoration of Citizenship, together with an original of a progress report from the supervising agent, to the board. This form may be obtained from the supervising officer. The board shall submit a recommendation to the governor regarding restoration of citizenship.

c. A person applying for restoration of citizenship more than 60 days after discharge of the person's sentence shall submit the Executive Clemency Application form to the governor. This form may be obtained from the governor's office or from the board. The governor shall obtain a recommendation regarding restoration of citizenship from the board.

205—14.4(248A,902) Board investigation. The board may investigate an application or district department recommendation with respect to history, current situation, parole prospects and other pertinent matters. The board may consider the application or recommendation, transcripts of judicial proceedings and all documents submitted with the application, and other documents as the board determines is appropriate and may interview public officials, victims, and witnesses, and other individuals as the board determines is appropriate.

205—14.5(248A,902) Executive clemency recommendations.

14.5(1) *Decision.* Rescinded IAB 6/28/00, effective 6/8/00.

14.5(2) *Notice of board recommendation.* The board shall give notice of an executive clemency recommendation to the office of the governor and, if requested, to the inmate or applicant.

14.5(3) *Board consideration following commutation.* The board shall consider the parole and work release prospects of an inmate whose sentence has been commuted by the governor.

14.5(4) *Executive clemency reconsiderations.*

a. The board may reconsider at any time a board recommendation to grant executive clemency that the governor has denied and returned to the board. The procedures for reviewing an executive clemency application shall apply to the reconsideration of a denied recommendation.

b. The board may refile the recommendation with the governor or withdraw the recommendation.

205—14.6(902) Commutation procedure for class "A" felons.

14.6(1) *Initial review.* The board of parole, or its designee, will initially review an application for commutation to determine whether the inmate is eligible for a commutation pursuant to Iowa Code section 902.2. If the inmate is not eligible to apply for commutation pursuant to Iowa Code section 902.2, the board shall return the application to the governor and notify the governor of the reasons.

14.6(2) *Parole board commutation investigation process.*

a. If the applicant is eligible to apply for commutation pursuant to Iowa Code section 902.2, the board shall conduct an investigation pursuant to that section and to subrule 14.6(2).

b. The board may consider any documents the board deems appropriate including, but not limited to, the application and attached documents, transcripts of judicial proceedings, corrections information, and written recommendations, statements, and interviews of public officials, victims, and witnesses.

c. The board shall interview the applicant, pursuant to Iowa Code section 902.2, prior to submitting its recommendation to the governor. The board may interview any other person the board deems appropriate including, but not limited to, public officials, victims, and witnesses. The board may conduct any interview, including the interview of the applicant, through electronic means.

d. The board shall attempt to provide notice of the commutation investigation to any individual who would qualify as a victim under Iowa's victim's notification law. Notice shall be by regular mail to the last-known address. The notice shall provide a specified amount of time for the victim to provide a statement to the board regarding the application for commutation.

e. The board may utilize the resources of the department of public safety for assistance with any part of its investigation.

f. The board may hold a public hearing to receive comments from the general public on an application for commutation. The determination to hold a public hearing to receive public comments is solely at the discretion of the board.

14.6(3) *Recommendation and report.*

a. The board shall vote on a recommendation regarding the application. Any decision to recommend commutation shall be by unanimous vote. The board may continue the matter until such time as the board may determine by majority vote.

b. The board may consider any factor it deems appropriate when considering commutation including, but not limited to, the nature and circumstances of the crime, the number of years the applicant has served, the applicant's previous criminal record, the applicant's conduct while confined, the impact on the victim, and the public interest.

c. The board shall prepare a written report of its findings and recommendations and forward its report to the governor.

14.6(4) *Board consideration following commutation.* The board shall consider the parole and work release prospects of any inmate whose life sentence has been commuted by the governor. The grant of commutation does not require the board to grant parole or work release. The board shall consider parole or work release pursuant to the standards in 205—Chapter 8.

These rules are intended to implement Iowa Code sections 902.2, 902.4, 904A.4(7) and chapter 914.

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- Professional and pedagogical knowledge via multiple measures. Examples include core performance tasks such as analyzing a child's progress on learning and development and instruction using a case study of a child; designing a curriculum unit; analyzing a curriculum case study; analyzing an example of teaching as presented on video clip or teacher candidate's own teaching, including an assessment on student learning; evaluating examples of performance of a range of school district and area education agency personnel; analyzing student work and learning over time; assessing feedback given by teachers to students; communicating with parents and the community; developing a school vision based on assessment data related to student learning; analyzing a budget plan; and other measures appropriate to a given task.
- Effect on student learning and achievement via multiple measures. Examples include student work, lesson plans, scores on achievement tasks, feedback from cooperating teachers and administrators, scoring rubrics for determining levels of student accomplishment, and other measures appropriate to a given task.

5. Include scoring rubrics or criteria for determining levels or benchmarks of teacher, administrator and other professional school personnel candidate accomplishment.

6. Demonstrate credibility such as reliability and validity of both the overall assessment system and the instruments being used.

(4) Document the quality of programs through the collective presentation of assessment data related to performance of teacher, administrator and other professional school personnel candidates and demonstrate how the data are used for continuous program improvement. This shall include:

1. Evidence of evaluative data collected by the department from teachers, administrators and other professional school personnel who work with the unit's candidates. The department shall report this data to the unit.

2. Evidence of evaluative data collected by the unit through follow-up studies of graduates and their employers.

(5) Demonstrate how the information gathered via the individual practitioner candidate assessment system is utilized to refine and revise the unit's framework and programs' goals, content and delivery strategies.

(6) Describe how the assessment system is managed.

(7) Explain the process for reviewing and revising the assessment system.

h. An annual report including a composite of evaluative data collected by the unit shall be submitted to the bureau of practitioner preparation and licensure by September 30 of each year.

These rules are intended to implement Iowa Code section 256.7 and 1999 Iowa Acts, House File 532, sections 1 and 3.

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CHAPTER 80
STANDARDS FOR PARAEDUCATOR PREPARATION PROGRAMS

281—80.1(272) General statement. Programs of preparation leading to certification of paraeducators in Iowa are subject to approval by the state board of education.

281—80.2(272) Definitions. The following definitions are used throughout this chapter:

"Department" means the department of education.

"Director" means director of the department of education.

"Institution" means a public school district, area education agency, community college, institution of higher education under the state board of regents or an accredited private institution as defined in Iowa Code section 261.9(1) offering paraeducator preparation program(s).

"Paraeducator candidate" means an individual who is enrolled in a paraeducator preparation program leading to certification as a generalist, generalist with area(s) of concentration, or advanced paraeducator.

"Paraeducator preparation program" means the program of paraeducator preparation leading to certification of paraeducators.

"State board" means Iowa state board of education.

"Unit" means the organizational entity within an institution with the responsibility of administering the paraeducator preparation program(s).

281—80.3(272) Institutions affected. All institutions engaged in preparation of paraeducators and seeking state board approval of their paraeducator preparation programs shall meet the standards contained in this chapter.

281—80.4(272) Criteria for Iowa paraeducator preparation programs. Each institution seeking approval of its paraeducator preparation program(s) shall file evidence of the extent to which it meets the standards contained in this chapter. After the state board has approved an institution's paraeducator preparation program(s), students who complete the program(s) may be recommended by the authorized official of that institution for issuance of the appropriate certificate.

281—80.5(272) Approval of programs. Approval of paraeducator preparation programs by the state board shall be based on the recommendation of the director after study of the factual and evaluative evidence on record about each program in terms of the standards contained in this chapter.

Approval, if granted, shall be for a term of five years; however, approval for a lesser term may be granted by the state board if it determines conditions so warrant.

If approval is not granted, the applicant institution will be advised concerning the areas in which improvement or changes appear to be essential for approval. In this case, the institution shall be given the opportunity to present factual information concerning its programs at the next regularly scheduled meeting of the state board. The institution may also reapply at its discretion to show what actions have been taken toward suggested improvement.

281—80.6(272) Periodic reports. Institutions placed on the approved programs list may be asked to make periodic reports upon request of the department which shall provide basic information necessary to keep records of each paraeducator preparation program up-to-date, and to provide information necessary to carry out research studies relating to paraeducator preparation.

281—80.7(272) Reevaluation of paraeducator preparation programs. Every five years, or at any time deemed necessary by the director, an institution shall file a self-evaluation of its paraeducator preparation programs.

281—80.8(272) Approval of program changes. Upon application by an institution, the director is authorized to approve minor additions to, or changes within, the institution's approved paraeducator preparation program. When an institution proposes revisions that exceed the primary scope of its programs, the revisions shall become operative only after having been approved by the state board.

281—80.9(272) Organizational and resources standards.

80.9(1) Unit faculty shall collaborate with members of the professional community, including the unit's advisory committee comprised of practitioners, to design, deliver, and evaluate programs to prepare paraeducators.

80.9(2) Unit faculty shall maintain ongoing actual involvement in settings where paraeducators are employed.

80.9(3) The unit's planning and evaluation system shall support paraeducator candidate performance and shall use assessment data to evaluate the effectiveness of the unit and its program.

281—80.10(272) Diversity.

80.10(1) Efforts toward racial, ethnic, and gender diversity among paraeducator candidates and unit faculty shall be documented. In addition, diversity efforts shall include persons with disabilities, persons from different language and socioeconomic backgrounds, and persons from different regions of the country and world.

80.10(2) Unit efforts in increasing or maintaining diversity shall be reflected in plans, monitoring of plans, and results.

281—80.11(272) Paraeducator candidate performance standards. Paraeducator candidate assessment and unit planning and evaluation shall include the following:

80.11(1) Performance of paraeducator candidates shall be measured against state certification standards adopted by the board of educational examiners under Iowa Code section 272.12 and the unit's learning outcomes.

80.11(2) Information on performance of paraeducator candidates shall be drawn from multiple assessments, including but not limited to unit assessment of content knowledge and its application as candidates work with students, teachers, parents, and other professional colleagues in school settings, and follow-up studies of certified paraeducators.

80.11(3) The unit's assessment system shall:

a. Provide paraeducator candidates with ongoing feedback about what elements of performance are being assessed and how performance is being assessed.

b. Demonstrate how the information gathered via the individual, paraeducator-candidate assessment system is utilized to refine and revise the unit's framework and program goals, content, and delivery strategies.

c. Explain the process for reviewing and revising the assessment system.

80.11(4) An annual report including a composite of evaluative data collected by the unit shall be submitted to the department by September 30 of each year.

These rules are intended to implement Iowa Code section 256.7 as amended by 2000 Iowa Acts, House File 2146, section 1.

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CHAPTER 81
REQUIREMENTS FOR SPECIAL EDUCATION ENDORSEMENTS

[Prior to 9/7/88, see Education Department[281]Ch 73]
[Transferred to Educational Examiners[282] Ch 15, IAB 10/3/90, effective 9/14/90]

CHAPTER 82
OCCUPATIONAL AND POSTSECONDARY CERTIFICATION AND ENDORSEMENTS

[Prior to 9/7/88, see Education Department[281]Ch 74]
[Transferred to Educational Examiners[282] Ch 16, IAC 10/3/90, effective 9/14/90]

421—2.13(22) Availability of records.

2.13(1) *General.* Agency records are open for public inspection and copying unless otherwise provided by rule or law.

2.13(2) *Confidential records.* The following records may be withheld from public inspection.

a. Information pertaining to clients receiving advocacy or referral services. (Iowa Code section 216A.6);

b. Tax records made available to the agency. (Iowa Code sections 422.20 and 422.72);

c. Records which are exempt from disclosure under Iowa Code section 22.7;

d. Minutes of closed meetings of a government body. (Iowa Code section 21.5(4));

e. Identifying details in final orders, decisions and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy under Iowa Code section 17A.3(1)*"d"*;

f. Those portions of agency staff manuals, instructions or other statements excluded from the definition of "rule." (Iowa Code section 17A.2(7)*"f"*);

g. Records which constitute an attorney work product, attorney-client communications, or which are otherwise privileged. (Iowa Code sections 22.7(4), 622.10, and 622.11 and chapter 622B);

h. Records received from other agencies pursuant to Iowa Code section 216A.136 that are confidential under state or federal law;

i. Personal information in personnel files including, but not limited to, evaluations, discipline, social security number, home address, gender, birth date, and medical and psychological evaluations;

j. Any other records made confidential by law.

2.13(3) *Authority to release confidential records.* The agency may have discretion to disclose some confidential records which are exempt from disclosure under Iowa Code section 22.7 or other law. Any person may request permission to inspect records withheld from inspection under a statute which authorizes limited or discretionary disclosure as provided in rule 2.4(22). If the agency initially determines that it will release such records, the agency may, where appropriate, notify interested parties and withhold the records from inspection as provided in subrule 2.4(3).

421—2.14(22) Personally identifiable information. This rule describes the nature and extent of personally identifiable information which is collected, maintained, and retrieved by the agency by personal identifier in record systems as defined in rule 2.1(22). For each record system, this rule describes the legal authority for the collection or maintenance of that information; the means of storage of that information and indicates when applicable; if a data processing system matches, collates, or permits the comparison of personally identifiable information in one record system with personally identifiable information in another record system; and when the record system is confidential, indicates the statutory authority. The record systems maintained within the agency are:

2.14(1) *Personnel records.*

a. The agency maintains files containing information about employees, families and dependents, and applicants for commission members or staff positions within the agency. These files include, but are not limited to, payroll records, biographical information, medical information relating to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding, information concerning employee benefits, affirmative action reports and other information concerning employees and related issues. The files are maintained by department and by division.

b. The legal authority for maintaining the records for state-funded programs in Iowa Code sections 19A.11 and 91A.6, and chapter 601K. The legal authority for maintaining the records for federally funded programs is P.L. 97-35, Subtitle B, Section 675(c), P.L. 93-569, Title 5, U.S.C. 552a, P.L. 93-415, P.L. 98-473, Title II, Chapter 14, P.L. 98-457 and other federal statutes from which federal funds are granted.

c. The information is maintained on paper and some parts are on a data processing system that matches, collates or permits the comparison of some personally identifiable information within the state's automated data processing system.

d. Certain information contained within this record system is confidential under the authority of Iowa Code section 22.7(11).

2.14(2) *Advocacy records.*

a. The agency maintains files containing information pertaining to clients receiving advocacy or referral services to help alleviate or solve a problem. Such information may include, but is not limited to, names and addresses of clients, documents or other material relating to advocacy issues, social or economic conditions or circumstances of particular clients, department or division evaluations of information about clients, medical or psychiatric data provided to the department or division concerning a client, and legal data related to the client. These files are maintained by division and may be indexed by advocacy files, client files, interpreting files or any direct service involving individual client assistance set forth in this rule or by statute.

b. The authority for maintaining these records is Iowa Code chapter 601K and P.L. 97-35, P.L. 93-569, P.L. 93-415, P.L. 98-473, P.L. 98-457 and other federal statutes from which federal funds are granted.

c. Most of the information is maintained on paper; however, some divisions have some records in computer form which are maintained by the respective division.

d. Information contained within this record system is confidential under the authority of Iowa Code subsection 22.7(18) and 1988 Iowa Acts, House File 2255.

2.14(3) *Fiscal records.*

a. The agency maintains files containing fiscal information for state-funded programs and federally funded grants or contracts that may contain personally identifiable information. These records are maintained by department and by division.

b. The authority for maintaining these records is Iowa Code chapter 601K, P.L. 97-35, P.L. 93-569, P.L. 93-415, P.L. 98-473, P.L. 98-457 and other federal statutes from which federal funds are granted.

c. These records are stored on paper and on the state's automated data processing system that matches, collates or permits the comparison of some personally identifiable information.

d. Certain information contained within this record system is confidential under the authority of Iowa Code section 22.7(11).

2.14(4) *General correspondence, mailing lists, and program or grant data.*

a. The agency maintains correspondence files, grant notices and applications, conference or committee listings and reports, commission meeting minutes, mailing lists, program and grant information including surveys or specialized reports and activities that contain some personally identifiable information that may include names, addresses or other descriptive data. These records are generally collected and maintained by division.

b. The authority for maintaining these records is Iowa Code chapter 601K, P.L. 97-35, P.L. 93-569, P.L. 93-415, P.L. 98-473, P.L. 98-457 and other federal statutes from which federal funds are granted.

c. The information is maintained on paper and in computer systems within each respective division.

d. These records are generally open to the public unless otherwise authorized to be confidential by law.

2.14(5) *Criminal and juvenile justice information obtained from other agencies.*

a. The agency maintains files containing criminal and juvenile justice information obtained from other agencies to conduct research and evaluations, to provide data and analytical information to federal, state and local governments, and to assist other agencies in the use of criminal and juvenile justice data. These files may contain personally identifiable information.

b. The agency maintains these records pursuant to the authority of Iowa Code sections 216A.136 and 216A.138 and by interagency agreements.

c. The information is maintained on paper, some of which is also in computer files, or in computer files and not on paper, or on a data processing system. Some of these files and systems are capable of matching, collating or permitting the comparison of some personally identifiable information.

d. Certain criminal and juvenile justice information contained within these records and record systems is confidential under state or federal law or rule.

421—2.15(22) Other groups of records. This rule describes groups of records maintained by the agency other than record systems retrieved by a personal identifier as defined in rule 2.1(22). These records are routinely available to the public. However, the agency's files of these records may contain confidential information as discussed in rule 2.13(22). All records are stored both on paper and in automated data processing systems, unless otherwise noted.

2.15(1) *Administrative records.* This includes documents concerning budget, inventory, annual reports, office policies, state forms and reports.

2.15(2) *Publications, resource and library materials.* This includes books, periodicals, newsletters, government documents and public reports. These materials would generally be open to the public; some may be protected by copyright law.

2.15(3) *Office publications.* The divisions distribute to the public a variety of materials including brochures and typed information regarding issues pertinent to their programs or constituent groups. Also included are statistical reports, program reports and news releases.

2.15(4) *Rule-making records.* These include documents generated during the rule-making process, including public comments, and are available for public inspection.

2.15(5) *All other records.* Records are open if not exempted from disclosure by law.

421—2.16(22) Availability to listings of specific record series in the department by division. A detailed listing of records is available to the public in the central administration office in paper or automated data processing form. This listing includes, by division, the record series name, a general description of the record series, record location, maintenance, physical medium, identifier by which the records are accessed, individuals who have routine access, whether the record is entirely public, entirely confidential, or partially public and partially confidential, whether the record has or does not have personally identifiable information, what forms are associated with the record series and whether or not there is computer matching of personally identifiable information.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and Iowa Code chapters 22 and 216A.

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HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.
Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

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1.7(8) *Organization.* No later than October 1 of each year, the governor's DD council shall organize by electing a chair, vice-chair, and executive committee.

a. The executive committee shall consist of the governor's DD council chair, vice-chair and three members at large, one of whom shall be the immediate past chair if a current member of the governor's DD council.

b. The executive committee may exercise the power of the governor's DD council between regular governor's DD council meetings but may not override a decision of the governor's DD council.

c. The governor's DD council has the authority to create other standing and special committees and task forces as deemed necessary and to create terms of office for officers, committees, and committee chairs.

(1) The members and chairs of standing and special committees shall be appointed by the chairperson from the governor's DD council's membership. Appointments shall be approved by the governor's DD council.

(2) Noncouncil members may serve as voting members of committees if approved by the governor's DD council and shall be subject to terms as determined by the governor's DD council.

(3) Committees may act based on a simple majority of those present.

(4) Committees may create temporary task forces to assist them in their work.

1.7(9) *Procedure.* In cases not covered by this rule, Robert's Rules of Order shall govern.

This rule is intended to implement Iowa Code sections 217.6 and 225C.3.

441—1.8(17A,217) Waivers of administrative rules (hereinafter referred to as exceptions to policy). Exceptions to the department's rules may be granted in individual cases upon the director's own initiative or upon request. No exception will be granted to a rule required by state statute or by federal statute or regulation. Any exception granted must be consistent with state and federal law.

1.8(1) *Procedures for requests.*

a. Requests for exceptions must be submitted in writing to the Appeals Section, Department of Human Services, 1305 E. Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114.

b. A request for an exception is independent from a departmental appeal under 441—Chapter 7. However, a request for an exception may be combined with an appeal of a proposed decision to the director under 441—Chapter 7. A request for an exception made prior to an appeal under 441—Chapter 7 may be denied pending an appeal where factual matters need to be developed.

c. A party requesting an exception must establish that the exception is appropriate. A request for an exception should include the following information where applicable and known to the requester:

(1) The name, address, and case number or state identification number of the person or entity for whom an exception is being requested and the person requesting the exception, if different from the person for whom an exception is being requested.

(2) The specific rule to which an exception is requested or the substance thereof.

(3) The specific exception requested.

(4) Facts relevant to the factors listed in subrule 1.8(2).

(5) A history of the department's action on the case.

(6) Any information known to the requester regarding the department's treatment of similar cases.

(7) The name, address, and telephone number of any person inside or outside the department with knowledge of the matter with respect to which the exception is requested.

(8) Releases of information authorizing persons with knowledge regarding the request to furnish the department information pertaining to the request.

d. Requests for exceptions shall be acknowledged within seven days. The department may give notice of the request to other affected parties. The department may also request additional information from the applicant.

e. The department shall issue a written decision on the request for an exception to policy within 120 days of receipt, unless the applicant agrees to a later date. If a request for an exception to policy has been filed in a contested case proceeding, the department may pend the request until after a final decision is issued.

f. A denial of a request for an exception is absolutely final and is not appealable under 441—Chapter 7.

g. A request for an exception does not delay the time to request an appeal under 441—Chapter 7 or for filing a petition for judicial review of a final decision in a contested case under Iowa Code section 17A.19.

h. A request for an exception is not required to exhaust administrative remedies before judicial review of department action under Iowa Code section 17A.19.

i. The department shall maintain a deidentified record of exceptions granted and denied indexed by rule available for public inspection.

1.8(2) *Policy.*

a. The director may grant an exception if the director finds, based on clear and convincing evidence, that:

(1) Failure to grant the exception will result in undue hardship;

(2) The exception will not substantially affect another person in an adverse manner;

(3) The exception is not prohibited by state or federal law; and

(4) The exception will not endanger public health, safety, or welfare.

b. The decision on whether an exception should be granted will be made at the complete discretion of the director after consideration of all relevant factors including, but not limited to, those in paragraph *"a"* and the following:

(1) The need of the person or entity directly affected by the exception. Exceptions will be granted only in cases of extreme need.

(2) Whether there are exceptional circumstances justifying an exception to the general rule applicable in otherwise similar circumstances.

(3) Whether granting the exception would result in net savings to the state or promote efficiency in the administration of programs or service delivery. Net savings or efficiency will make an exception more likely.

(4) In the case of services, assistance, or grants, whether other possible sources have been exhausted. Exceptions will not generally be granted if other sources are available.

(5) The cost of the exception to the state and the availability of funds in the department's budget.

This rule is intended to implement Iowa Code section 217.6 and 2000 Iowa Acts, House File 2206.

441—1.9(17A) Commission on children, youth and families. Rescinded IAB 10/7/98, effective 12/1/98.

441—1.10(17A) HAWK-I board. The director of the department has, by statute, the advice and counsel of the HAWK-I board on the healthy and well children in Iowa program. This seven-member board consists of the commissioner of insurance or the commissioner's designee, the director of the department of education or the director's designee, the director of the department of public health or the director's designee, and four public members appointed by the governor, subject to confirmation by two-thirds of the members of the senate. The board shall also include two members of the senate and two members of the house of representatives, serving as ex officio members.

1.10(1) *Organization.*

a. The members of the board shall annually elect from the board's voting membership a chairperson of the board.

b. Members appointed by the governor and the legislative members shall serve two-year terms.

1.10(2) *Duties and powers of the board.* The board's powers and duties are to make policy and to provide direction for the administration of all aspects of the healthy and well kids in Iowa program which is administered by the division of medical services. In carrying out these duties, the board shall do all of the following:

a. Adopt rules of the department.

b. Develop criteria for and approve all contracts.

c. Establish a clinical advisory committee.

d. Establish an advisory committee on children with special health care needs.

e. Conduct studies and evaluations and provide reports as directed by legislation.

f. Define regions of the state for which plans are offered.

g. Solicit input from the public about the program.

h. Improve interaction between the program and other public and private programs which provide services to eligible children.

i. Receive and accept grants, loans, or other advances of funds from any person and may receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purpose of the program.

1.10(3) *Board action.*

a. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

b. When a quorum is present, a position is carried by a majority of the qualified members of the board.

1.10(4) *Board minutes.*

a. Copies of administrative rules and other materials considered are made part of the minutes by reference.

b. Copies of the minutes are kept on file in the office of the administrator of the division of medical services.

1.10(5) *Board meetings.*

a. The board shall meet at regular intervals at least ten times each year and may hold special meetings at the call of the chairperson or at the request of a majority of the voting members.

b. Any person wishing to make a presentation at a board meeting shall notify the Administrator, Division of Medical Services, Department of Human Services, Hoover State Office Building, Des Moines, Iowa 50309-0114, telephone (515)281-8794, at least 15 days prior to the board meeting.

1.10(6) *Robert's Rules of Order.* In cases not covered by these rules, Robert's Rules of Order shall govern.

This rule is intended to implement Iowa Code paragraph 17A.3(1)*"a"* and 1998 Iowa Acts, chapter 1196, section 6.

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

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

7.6(1) *Written and oral notification.* The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance.

a. The right to request a hearing.

b. The procedure for requesting a hearing.

c. The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.

d. Provisions, if any, for payment of legal fees by the department.

Written notification shall be given on the application form and pamphlets prepared by the agency for applicants and recipients. Explanation shall be included in the agency pamphlets explaining the various provisions of the program. Oral explanation shall also be given regarding the policy on appeals during the application process and at the time of any contemplated action by the agency when the need for an explanation is indicated. Persons not familiar with English shall be provided a translation into the language understood by them in the form of a written pamphlet or orally. In all cases when a person is illiterate or semiliterate, the person shall, in addition to receiving the written pamphlet on rights, be advised of each right to the satisfaction of the person's understanding.

7.6(2) *Representation.* All persons shall be advised that they may be represented at hearings by others, including legal counsel, relatives, friends, or any other spokesperson of choice, unless otherwise specified by statute or federal regulations. The agency shall advise the persons of any legal services which may be available and assist in securing the services if the persons desire.

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

7.7(1) *Notification.* Whenever the department proposes to terminate, reduce, or suspend food stamps, financial assistance, Medicaid, or services, it shall give timely and adequate notice of the pending action, except when a service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year or as provided in subrule 7.7(2). Whenever the department proposes to approve or deny food stamps, financial assistance, Medicaid, or services, it shall give adequate notice of the action.

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

b. Adequate means a written notice that includes:
(1) A statement of what action is being taken,
(2) The reasons for the intended action,
(3) The manual chapter number and subheading supporting the action,
(4) An explanation of the appellant's right to appeal, and
(5) The circumstances under which assistance is continued when an appeal is filed.

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

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

b. The recipient provides a clear written, signed statement that the recipient no longer wishes assistance, or gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands this must be the consequence of supplying the information.

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

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

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

f. The county establishes that the recipient has been accepted for assistance in a new jurisdiction.

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

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

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

j. Rescinded, effective 2/1/84.

k. The agency terminates, reduces, or suspends benefits or makes changes based on the completed Form 470-0455 or Form 470-3719(S), Public Assistance Eligibility Report, or Form 470-2881, Review/Recertification Eligibility Document, as described at 441—paragraph 40.27(1)*"b."*

l. The agency terminates benefits for failure to return a completed monthly report form, as described in paragraph *"k."*

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

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

c. To the degree practicable, the agency shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

7.24(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

7.24(4) *Completion of proceedings.* After the issuance of an emergency adjudicative order, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger. Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

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◊Two ARCs

9.3(7) *Fees.*

a. When charged. The agency may charge fees in connection with the examination or copying of records only if the fees are authorized by law. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

b. Copying and postage costs. Price schedules for published materials and for photocopies of records supplied by the agency shall be prominently posted in agency offices. Copies of records may be made by or for members of the public on agency photocopy machines or from electronic storage systems at cost as determined and posted in agency offices by the custodian. When the mailing of copies of records is requested, the actual costs of such mailing may also be charged to the requester.

c. Supervisory fee. An hourly fee may be charged for actual agency expenses in supervising the examination and copying of requested records when the supervision time required is in excess of one-half hour. The custodian shall prominently post in agency offices the hourly fees to be charged for supervision of records during examination and copying. That hourly fee shall not be in excess of the hourly wage of an agency clerical employee who ordinarily would be appropriate and suitable to perform this supervisory function.

d. Advance deposits.

(1) When the estimated total fee chargeable under this subrule exceeds $25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee.

(2) When a requester has previously failed to pay a fee chargeable under this subrule, the custodian may require advance payment of the full amount of any estimated fee before the custodian processes a new request from that requester.

e. Subscription to policy manuals. Subscriptions to all or part of the agency's employees' manual are available at the cost of production and handling. Requests for subscription information should be addressed to the Bureau of Policy Analysis, Department of Human Services, Hoover State Office Building, Des Moines, Iowa 50319-0114.

441—9.4(17A,22) Access to confidential records. Under Iowa Code section 22.7 or other applicable provisions of law, the lawful custodian may disclose certain confidential records to one or more members of the public. Other provisions of law authorize or require the custodian to release specified confidential records under certain circumstances or to particular persons. In requesting the custodian to permit the examination and copying of such a confidential record, the following procedures apply and are in addition to those specified for requests for access to records in rule 441—9.3(17A,22).

9.4(1) *Proof of identity.* A person requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record.

9.4(2) *Requests.* The custodian may require a request to examine and copy a confidential record to be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons justifying access to the confidential record and to provide any proof necessary to establish relevant facts.

9.4(3) *Notice to subject of record and opportunity to obtain injunction.* Except as provided in subrule 175.14(2), after the custodian receives a request for access to a confidential record, and before the custodian releases such a record, the custodian may make reasonable efforts to notify promptly any person who is a subject of that record, is identified in that record, and whose address or telephone number is contained in the record. To the extent such a delay is practicable and in the public interest, the custodian may give the subject of such a confidential record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8, and indicate to the subject of the record the specific period of time during which disclosure will be delayed for that purpose.

9.4(4) *Request denied.* When the custodian denies a request for access to a confidential record, the custodian shall promptly notify the requester. If the requester indicates to the custodian that a written notification of the denial is desired, the custodian shall promptly provide such a notification that is signed by the custodian and that includes:

a. The name and title or position of the custodian responsible for the denial; and

b. A citation to the provision of law vesting authority in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to this requester.

9.4(5) *Request granted.* Except as provided in subrule 175.14(2), when the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

9.4(6) *Records requiring special procedures.* Special procedures are required for access to:

a. Child abuse information. Access to child abuse information is obtained according to rules 441—175.8(235A) and 441—175.9(235A).

b. Dependent adult abuse information. Access to adult abuse information is governed by rule 441—176.10(235A).

c. Quarterly list. Rescinded IAB 10/4/00, effective 12/1/00.

441—9.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examinations. The custodian may treat a record as a confidential record and withhold it from examination only to the extent that the custodian is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order, to refuse to disclose that record to members of the public.

9.5(1) *Persons who may request.* Any person who would be aggrieved or adversely affected by disclosure of a record and who asserts that Iowa Code section 22.7, another applicable provision of law, or a court order, authorizes the custodian to treat the record as a confidential record, may request the custodian to treat that record as a confidential record and to withhold it from public inspection.

9.5(2) *Request.* A request that a record be treated as a confidential record and be withheld from public inspection shall be in writing and shall be filed with the custodian. The request must set forth the legal and factual basis justifying such confidential record treatment for that record, and the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request. A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit enumerating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts. Requests for treatment of a record as such a confidential record for a limited time period shall also specify the precise period of time for which that treatment is requested.

A person filing such a request shall, if possible, accompany the request with a copy of the record in question from which those portions for which such confidential record treatment has been requested have been deleted. If the original record is being submitted to the agency by the person requesting such confidential treatment at the time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are confidential.

9.10(4) *Agreements with other agencies.*

a. The agency may enter into agreements with public or private agencies, such as the department of inspections and appeals or the Medicaid fiscal agent, in order to carry out the agency's official duties. Information necessary to carry out these duties may be shared with these agencies.

b. The agency may enter into agreements to share information with agencies administering federal or federally assisted programs which provide assistance or services directly to individuals on the basis of need. Only information collected in the aid to dependent children program, the food stamp program, refugee resettlement program or the child support recovery program may be shared under these agreements.

c. To meet federal income and eligibility verification requirements, the agency has entered into agreements with the Iowa department of employment services, the United States Internal Revenue Service, and the United States Social Security Administration. The agency obtains information regarding persons whose income or resources are considered in determining eligibility and the amount of benefits for aid to dependent children, refugee cash assistance, food stamps, medical assistance, state supplementary assistance and foster care. Identifying information regarding these people is released to these agencies. The information received may be used for eligibility and benefit determinations.

d. To meet federal requirements under the Immigration Reform and Control Act of 1986 (IRCA) relating to the Systematic Alien Verification for Entitlements (SAVE) program, the agency has entered into an agreement with the Immigration and Naturalization Service (INS) to exchange information necessary to verify alien status for the purpose of determining eligibility and the amount of benefits for aid to dependent children, refugee cash assistance, food stamps, medical assistance, state supplementary assistance and foster care assistance. Identifying information regarding these people is released to the INS. The information received may be used for eligibility and benefit determination.

e. The agency has entered into an agreement with the department of workforce development under which the agency will provide services to family investment program clients participating in the PROMISE JOBS program as described at 441—Chapter 93. Information necessary to carry out these duties shall be shared with the agency, as well as with the agency's subcontractors.

f. State legislation requires that all emergency assistance households apply for and accept benefits for which they may qualify from the energy assistance, county general relief and veteran's affairs programs before approval for emergency assistance. To meet this requirement, the department may enter into agreements with the agencies that administer these programs under which they may provide services to emergency assistance households as described at 441—Chapter 58. Information necessary to carry out these duties shall be shared with these agencies.

9.10(5) *Release to court.* Information is released to the court as required in Iowa Code sections 125.80, 125.84, 125.86, 229.8, 229.10, 229.13, 229.14, 229.15, 229.22, 232.48, 232.49, 232.52, 232.71, 232.81, 232.97, 232.98, 232.102, 232.111, 232.117 and 235B.1.

When a court subpoenas information that the agency is prohibited from releasing, the agency shall advise the court of the statutory and regulatory provisions against disclosure of the information and disclose the information only on order of the court.

9.10(6) *Fraud.* Information concerning suspected fraud or misrepresentation to obtain agency services or assistance is disclosed to the department of inspections and appeals and to law enforcement authorities.

9.10(7) *Service referrals.* Information concerning clients may be shared with purchase of service providers under contract to the agency.

Information concerning the client's circumstances and need for service is shared with prospective providers to obtain placement. If the client is not accepted for service all written information released to the provider shall be returned to the agency.

When the information needed by the provider is mental health information or substance abuse information, the client's specific consent is required in subrule 9.3(4).

9.10(8) *Medicaid billing.* Only the following information shall be released to bona fide providers of medical services in the event that the provider is unable to obtain it from the subject and is unable to complete the Medicaid claim form without it:

a. Patient identification number.

b. Health coverage code as reflected on the subject's medical card.

c. The subject's date of birth.

d. The subject's eligibility status for the month that the service was provided.

9.10(9) *County billing.* Information necessary for billing is released to county governments that pay part of the cost of care for local purchase services under rule 441—150.6(234), intermediate care facility services for the mentally retarded under subrule 82.14(2), or Medicaid waiver services under rule 441—83.9(249A). This information includes client names, identifying numbers, provider names, number of days of care, amount of client payment, and amount of payment due.

9.10(10) *Child support recovery.* The child support recovery unit has access to information from most agency records for the purpose of establishing and enforcing support obligations. Information about absent parents and recipients of child support services is released according to the provisions of Iowa Code chapters 234, 252A, 252B, 252C, 252D, 252E, 252F, 252G, 252H, 598, 600B, and any other support chapter. Information is also released to consumer reporting agencies as specified in rule 441—95.12(252B).

9.10(11) *Refugee resettlement program.* Contacts with both sponsor and resettlement agencies are made as a part of the verification process to determine eligibility or the amount of assistance. When a refugee applies for cash or Medicaid, the refugee's name, address, and telephone number are given to the refugee's local resettlement agency.

9.10(12) *Abuse investigation.* The central abuse registry disseminates child abuse information as provided in Iowa Code section 235A.15 and dependent adult abuse information as provided in 441—Chapter 176. Reports of child abuse and dependent adult abuse investigations are submitted to the county attorney as required in Iowa Code sections 232.71 and 235B.1. Results of the investigation of a report by a mandatory reporter are communicated to the reporter as required in Iowa Code sections 235A.17(5) and 235A.15(2)*"j."*

9.10(13) *Foster care.* Information concerning a child's need for foster care is shared with foster care review committees or foster care review boards and persons named in the case permanency plan.

9.10(14) *Adoption.* Adoptive home studies completed on families who wish to adopt a child are released to licensed child-placing agencies, to the United States Immigration and Naturalization Service, and to adoption exchanges. Information is released from adoption records as provided in Iowa Code sections 600.16 and 600.24.

9.10(15) *Quarterly list.* Rescinded IAB 10/4/00, effective 12/1/00.

9.10(16) *Response to law enforcement.* The address of a current recipient of family investment program benefits may be released upon request to a federal, state or local law enforcement officer if the officer provides the name of the recipient, and the officer demonstrates that:

a. The recipient is a fugitive felon who is fleeing prosecution, custody or confinement after conviction under state or federal law, or who is a probation or parole violator under state or federal law, or

b. The recipient has information that is necessary for the officer to conduct the officer's official duties, and

c. The location or apprehension of the recipient is within the officer's official duties.

g. Regulatory files on individual providers. Files on individuals who apply to be licensed, certified, registered, or approved by the agency contain identifying information, a description of the person's operation or premises, an agency evaluation of the information collected. Files may contain data on criminal records and abuse registry records on the individual and any employees. Files may contain information naming clients served (for example in complaints or incident reports). Some of these records are also kept on microfilm.

h. Personnel files. The agency maintains files containing information about employees, families and dependents, and applicants for paid or volunteer positions within the agency. The files contain payroll records, biographical information, medical information pertaining to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding and information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship.

9.12(2) *Data processing matching.*

a. Internal. All data processing systems operated by the agency which have comparable personally identifiable data elements permit the matching of personally identifiable information. (See subrule 9.12(1) for a description of these systems.) Matches which are routinely done include the following:

(1) Data from the service reporting system is matched with data from the purchase of service payment system for service eligibility and with the activity reporting system for cost allocation. Matches are also done with the state identification portion of the automated benefit calculation system.

(2) The automated benefit calculation system matches with the Medicaid eligibility system, the facility payment system, the child support collections system, the food stamp issuance system, the Medicare buy-in system, and the income eligibility and verification system.

(3) The Medicaid eligibility system matches information with the Medicaid management information system and the collection and recovery system.

b. External.

(1) The state data exchange matches information on agency clients with records on recipients of supplemental security income.

(2) The Medicare buy-in system matches information with the Social Security Administration.

(3) The income and eligibility verification system matches information on agency clients with income records from department of employment services records on unemployment compensation and wages, tax records from the Internal Revenue Service, wage records and social security benefit records from the Social Security Administration, and public assistance records from other states.

(4) Data from the collections and reporting system is matched with state and federal tax records, and with client records on the automated benefit calculation system.

(5) Data on agency clients is matched with records on workers' compensation from the industrial commission, with the administering agency for the Job Training Partnership Act, and with private agencies working to help employers collect benefits under the targeted jobs tax credit program.

(6) Reports on disqualified food stamp recipients from other states are received from the United States Department of Agriculture to ensure that recipients are not evading penalties by reapplying in Iowa.

(7) A list of recipients of benefits under the family investment program is released annually to the Internal Revenue Service for matching with records of dependents claimed.

(8) A list of applicants for and recipients of the family investment program (FIP), the family medical assistance program (FMAP), FMAP-related medical assistance, and the food stamp program is matched with records on Iowa motor vehicle registration files to assist in the identification of countable resources.

c. Centralized employee registry (CER) database. The CER receives data concerning employees and contractors who perform labor in Iowa. Information reported by Iowa employers about employees includes the employee's name, address, social security number, date of birth, beginning date of employment, whether health insurance is available, and when it may be available. Information reported by Iowa income payers about contractors is limited to the contractor's name, address, social security number, and date of birth, if known.

State agencies accessing the CER shall participate in proportionate cost sharing for accessing and obtaining information from the registry. Cost sharing shall include all costs of performing the match including costs for preparing the tapes and central processing unit time. Costs shall be specified in a 28E agreement with each agency. CER matches include the following. Data matches with:

(1) The child support collections and reporting system for the establishment and enforcement of child and medical support obligations.

(2) Other DHS systems for the purpose of gathering additional information and verification for use in the determination of eligibility or calculation of benefits.

(3) The department of employment services for the determination of eligibility or calculation of unemployment benefits, and to monitor employer compliance with job insurance tax liability requirements.

(4) The department of workforce development to verify employment of participants in the PROMISE JOBS program.

(5) The department of revenue and finance for the recoupment of debts to the state.

(6) The department of inspections and appeals for the recoupment of debts owed to DHS.

441—9.13(217) Distribution of informational materials.

9.13(1) *Requirements for distribution.* All material sent or distributed to clients, vendors, or medical providers shall:

a. Directly relate to the administration of the program.

b. Have no political implications.

c. Contain the names only of persons directly connected with the administration of the program.

d. Identify them only in their official capacity with the agency.

9.13(2) *Distribution prohibited.* The agency shall not distribute materials such as holiday greetings, general public announcements, voting information, and alien registration notices.

9.13(3) *Distribution permitted.* The agency may distribute materials directly related to the health and welfare of clients, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

These rules are intended to implement Iowa Code sections 17A.3, 22.11, 217.6 and 217.30, and Iowa Code chapters 228 and 252G.

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441—25.53(77GA,HF2545) Methodology for awarding incentive funding. Each county shall report on all performance measures listed in this division, plus any additional performance measures the county has selected, by December 1 of each year.

25.53(1) *Reporting.* Each county shall report performance measure information on forms, or by electronic means, developed for the purpose by the department in consultation with the state county management committee.

25.53(2) *Scoring.* The department shall analyze each county's report to determine the extent to which the county achieved the levels contained in the proposal accepted by the state county management committee. Prior to distribution of incentive funding to counties, results of the analysis shall be shared with the state county management committee.

25.53(3) *County ineligibility.* A county which does not report performance measure data by December 1 will be ineligible to receive incentive funds for that fiscal year. A county may apply for an extension by petitioning the state county management committee prior to December 1. The petition shall describe the circumstances which will cause the report to be delayed and identify the date by which the report will be submitted.

441—25.54(77GA,HF2545) Subsequent year performance factors. For any fiscal year which begins after July 1, 1999, the state county management committee shall not apply any additional performance measures until the county management information system (CoMIS) developed and maintained by the division of mental health and developmental disabilities has been modified, if necessary, to collect and calculate required data elements and performance measures and each county has been given the opportunity to establish baseline measures for those measures.

441—25.55(77GA,HF2545) Phase-in provisions.

25.55(1) *State fiscal year 1999.* For the fiscal year which begins July 1, 1998, each county shall collect data as required above in order to establish a baseline level on all performance measures. A county which collects and reports all required data by December 1, 1999, shall be deemed to have received a 100 percent score on the county's performance indicators.

25.55(2) *State fiscal year 2000.* A county which submits a proposal with its management plan for the fiscal year which begins July 1, 1999, and reports the levels achieved on the selected performance measures by December 1, 2000, shall be deemed to have received a 100 percent score on the county's performance indicators, regardless of the actual levels achieved.

These rules are intended to implement 1998 Iowa Acts, House File 2545, section 8, subsection 2.

441—25.56 to **25.60** Reserved.

DIVISION V
RISK POOL FUNDING

PREAMBLE

These rules establish a risk pool board to administer the risk pool fund established by the legislature and set forth the requirements for counties for receiving and repaying funding from the fund.

441—25.61(426B) Definitions.

"Aggregate application" means the request for funding when a county has an unanticipated cost for mental health, mental retardation, and developmental disabilities services fund expenditures that would result in the county's current fiscal year budget exceeding the sum of 105 percent of the county's current fiscal year budget amount and the county's prior fiscal year accrual ending fund balance exceeding 25 percent of the prior fiscal year gross services fund expenditures.

"Available pool" means those funds remaining in the risk pool less any actuarial and other direct administrative costs.

"Commission" means the mental health and developmental disabilities commission.

"Division" means the mental health and developmental disabilities division of the department of human services.

"Individual application" means the request for funding when a county has individuals who have unanticipated disability conditions with an exceptional cost and the individuals are either new to the county's service system or the individuals' disability conditions have changed or are new.

"Loan" means the risk pool funds a county received in a fiscal year in which the county did not levy the maximum amount allowed for the county's mental health, mental retardation, and developmental disabilities services fund under Iowa Code section 331.424A.

441—25.62(426B) Risk pool board. This nine-member board consists of two county supervisors, two county auditors, a member of the state-county management committee created in Iowa Code section 331.438 who was not appointed by the Iowa state association of counties, a member of the county finance committee created in Iowa Code chapter 333A who is not an elected official, two single entry point process administrators, all appointed by the governor, subject to confirmation by two-thirds of the members of the senate, and one member appointed by the director of the department of human services.

25.62(1) *Organization.*

a. The members of the board shall annually elect from the board's voting membership a chairperson and vice-chairperson of the board.

b. Members appointed by the governor shall serve three-year terms.

25.62(2) *Duties and powers of the board.* The board's powers and duties are to make policy and to provide direction for the administration of the risk pool established by Iowa Code section 426B.5, subsection 3. In carrying out these duties, the board shall do all of the following:

a. Recommend to the commission for adoption rules governing the risk pool fund.

b. Determine application requirements to ensure prudent use of risk pool assistance.

c. Accept or reject applications for assistance in whole or in part.

d. Review the fiscal year-end financial records for all counties that are granted risk pool assistance and determine if repayment is required.

e. Approve actuarial and other direct administrative costs to be paid from the pool.

f. Perform any other duties as mandated by law.

25.62(3) *Board action.*

a. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

b. When a quorum is present, an action is carried by a majority of the qualified members of the board.

25.62(4) *Board minutes.*

a. Copies of administrative rules and other materials considered are made part of the minutes by reference.

b. Copies of the minutes are kept on file in the office of the administrator of the division of mental health and developmental disabilities.

25.62(5) *Board meetings.*

a. The board shall meet in April of each year and may hold special meetings at the call of the chairperson or at the request of a majority of the voting members.

b. Any county making application for risk pool funds must be represented at the board meeting when that request is considered. The division shall notify the county of the date, time and location of the meeting. Any other persons with questions about the date, time or location of the meeting may contact the Administrator, Division of Mental Health and Developmental Disabilities, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut, Des Moines, Iowa 50309-0114, telephone (515)281-5874.

c. The board shall comply with applicable provisions of Iowa's open meetings law, Iowa Code chapter 21.

25.62(6) *Records.* Any records maintained by the board or on behalf of the board shall be made available to the public for examination in compliance with Iowa's open records law, Iowa Code chapter 22. To the extent possible, prior to submitting applications, records and documents, applicants shall delete any confidential information. These records shall be maintained in the office of the division of mental health and developmental disabilities.

25.62(7) *Conflict of interest.* A board member cannot be a part of any presentation to the board of that board member's county's application for risk pool funds nor can the board member be a part of any action pertaining to that application.

25.62(8) *Robert's Rules of Order.* In cases not covered by these rules, Robert's Rules of Order shall govern.

441—25.63(426B) Application process.

25.63(1) *Applicants.* A county may make an aggregate or individual application at any time on or before April 1 of any given year for the current fiscal year budget whenever the projected need exceeds the sum of 105 percent of the county's current fiscal year budget amount and the county's prior fiscal year accrual ending fund balance exceeds 25 percent of the prior fiscal year gross services fund expenditures.

The purpose of the mental health risk pool is to assist counties whose expenditures in the mental health, mental retardation, and developmental disabilities services fund exceed budgeted costs due to unanticipated expenses for new individuals or other unexpected factors. The mental health risk pool is not intended for multiyear usage or as a source of planned revenue.

25.63(2) *Application procedures.* The county shall send Form 470-3723, Risk Pool Application, plus 15 copies, to the division. The division must receive the application no later than 4:30 p.m. on April 1 of each year; or, if April 1 is a holiday, a Saturday or Sunday, the division must receive the application no later than 4:30 p.m. on the first working day thereafter. Facsimiles and electronic mail are not acceptable. The application shall be signed and dated by both the chairperson of the county board of supervisors and the central point of coordination administrator. Staff of the division shall notify each county of receipt of the county's application.

The county shall attach the following forms to the application:

a. Form 634A, Revenues Detail.

b. Form 634B, Service Area Detail (pages 1 to 10).

c. Form 634C, Service Area 4 Supporting Detail (pages 1 to 8).

d. Form 638R, Statement of Revenues, Expenditures, and Changes in Fund Balance—Actual and Budget (pages 1 and 2).

e. If the budget has been amended, Form 653A-R, Record of Hearing and Determination on the Amendment to County Budget (sheet 2), for both the current fiscal year budget, as last amended, and the prior fiscal year gross services fund expenditures.

25.63(3) *Request for additional information.* Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county within four working days after April 1 or the first working day thereafter, if April 1 is a holiday, a Saturday or Sunday, to request the information needed to complete the application. The county shall submit the required information within five working days from the date of the division's request for the additional information.

441—25.64(426B) Methodology for awarding risk pool funding.

25.64(1) *Notice of decision.* The risk pool board shall send a notice of decision of the board's action to the chairperson of the applying county's board of supervisors. Copies of the notice of decision shall be sent to the county auditor and the central point of coordination administrator.

25.64(2) *Distribution of funds.* The total amount of the risk pool shall be limited to the available pool for a fiscal year. If the total dollar amount of the approved applications exceeds the available pool, the board shall prorate the amount paid for an approved application. The funds will be prorated to each county based upon the proportion of each approved county's request to the total amount of all approved requests.

441—25.65(426B) Repayment provisions.

25.65(1) *Required repayment.* Counties shall be required to repay risk pool funds in the following situations:

a. A loan was granted to the county because the county did not levy the maximum amount allowed for the county's mental health, mental retardation, and developmental disabilities services fund under Iowa Code section 331.424A. The county shall be required to repay the risk pool loan funds during the two succeeding fiscal years. The repayment amount shall be limited to the amount by which the actual amount levied was less than the maximum amount allowed.

b. The county had levied the maximum amount allowed for the county's mental health, mental retardation, and developmental disabilities services fund, but the county's actual need for risk pool assistance was less than the amount of risk pool assistance granted to the county. The county shall refund the difference between the amount of assistance granted and the actual need.

25.65(2) *Year-end report.* Each county granted risk pool funds shall complete a year-end financial report. The division shall review the accrual information and notify the mental health risk pool board if any county that was granted assistance in the prior year received more than the county's actual need based on the submitted financial report.

25.65(3) *Notification to county.* The chairperson of the mental health risk pool board shall notify each county by January 1 of each fiscal year of the amount to be reimbursed. The county shall reimburse the risk pool within 30 days of receipt of notification by the chairperson of the mental health risk pool board. If a county fails to reimburse the mental health risk pool, the board may request a revenue offset through the department of revenue and finance. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the central point of coordination administrator of the county.

441—25.66(426B) Appeals. The risk pool board may accept or reject an application for assistance from the risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement Iowa Code section 426B.5, subsection 3.

441—25.67 to **25.70** Reserved.

DIVISION VI
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

PREAMBLE

These rules provide for use of an appropriation from the tobacco settlement fund to establish a risk pool fund which may be used by counties with limited county mental health, mental retardation and developmental disabilities services funds to pay for increased compensation of the service staff of eligible purchase of service (POS) providers and establish the requirements for counties for receiving and repaying the funding. Implementation of the rate increases contemplated by the tobacco settlement fund in a timely manner will require cooperation among all eligible counties and providers.

441—25.71(78GA,HF2555) Definitions.

"Adjusted actual cost" means a POS provider's cost as computed using the financial and statistical report for the provider's fiscal year which ended during the state fiscal year beginning July 1, 1998 (state fiscal year 1999), as adjusted by multiplying those actual costs by 103.4 percent or the percentage adopted by the risk pool board in accordance with 2000 Iowa Acts, House File 2555, section 3, subsection 3, paragraph *"c."*

25.75(3) *Distribution of funds.* The total amount of the risk pool shall be limited to $2 million. If the total dollar amount of the eligible applications exceeds the available pool, the risk pool board shall revise the percentage adjustment to actual cost to arrive at adjusted actual cost as defined in this division and prorate funding to the eligible counties. If it becomes necessary to revise the percentage adjustment used to determine adjusted actual cost, the risk pool board shall determine if applicant counties remain eligible under this program.

25.75(4) *Notification of adjustment.* If the risk pool board rolls back the percentage adjustment used to determine adjusted actual cost, the risk pool board shall notify the chair of the board of supervisors of all counties, and copies shall be sent to the county auditor and the CPC administrator of each county. Each host county shall recalculate the reimbursement rate under this division using the revised adjusted actual cost percentage and notify each provider in writing of the revised rate within 30 days of receiving notice of the percentage adjustment. The provider shall, within 30 days of receipt of notice, send to the CPC administrator of any other counties with consumers in those programs a copy of the revised rate determination signed by the CPC administrator of the host county.

441—25.76(78GA,HF2555) Repayment provisions.

25.76(1) *Required repayment.* Counties shall be required to repay TSF loans by January 1, 2002. Repayments shall be credited to the tobacco settlement fund.

25.76(2) *Notification to county.* In the notice of decision provided pursuant to these rules, the chairperson of the risk pool board shall notify each county of the portion, if any, of the assistance that is considered a TSF loan. If a county fails to reimburse the tobacco settlement fund by January 1, 2002, the board may request a revenue offset through the department of revenue and finance. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the CPC administrator of the county.

441—25.77(78GA,HF2555) Appeals. The risk pool board may accept or reject an application for assistance from the tobacco settlement fund risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement 2000 Iowa Acts, House File 2555, section 3, as amended by Senate File 2452, section 4.

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CHAPTER 26
COUNTY MAINTENANCE OF EFFORT CALCULATIONS AND REPORTING
Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 27
Reserved

TITLE IV
FAMILY INVESTMENT PROGRAM

CHAPTER 40
APPLICATION FOR AID

[Prior to 7/1/83, Social Services[770] Ch 40]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

[Rescinded IAB 2/12/97, effective 3/1/97]

441—40.1 to **40.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, 441—40.1(239) to 40.9(239)]

441—40.21(239B) Definitions.

"Applicant" means a person for whom assistance is being requested, parent(s) living in the home with the child(ren), and the nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child(ren).

"Assistance unit" includes any person whose income is considered when determining eligibility or the amount of assistance for aid to dependent children.

"Budgeting process" means the process by which income is computed to determine eligibility under the 185 percent eligibility test described in 441—41.27(239B), Initial eligibility, the initial family investment program grant, ongoing eligibility, and the ongoing family investment program grant.

1. For retrospective budgeting, the budget month is the second month preceding the payment month.

2. For prospective budgeting, the budget month and payment month are the same calendar month.

"Budget month" means the calendar month from which the local office uses income or circumstances of the eligible group to compute eligibility and the amount of assistance.

"Central office" shall mean the state administrative office of the department of human services.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Department" shall mean the Iowa department of human services.

"Income in kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary or in-kind benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which assistance is paid. This may include a month for which a partial payment is made.

Whenever *"medical institution"* is used in this title, it shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals
2. Extended care facilities (skilled nursing)
3. Intermediate care facilities
4. Mental health institutions
5. Hospital schools

"Payment month" means the calendar month for which assistance is paid.

"Payment standard" means the total needs of a group as determined by adding need according to the schedule of basic needs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

"Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) programs" means the department's training program as described in 441—Chapter 93, Division II.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Recipient" means a person for whom assistance is paid, parent(s) living in the home with the eligible child(ren) and nonparental relative as defined in 441—subrule 41.22(3) who is receiving assistance for the child(ren). Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Report month" for retrospective budgeting means the calendar month following the budget month. "Report month" for prospective budgeting means the calendar month in which a change occurs.

"Retrospective budgeting" means the computation of the amount of assistance for a payment month based on actual income and circumstances which existed in the budget month.

"Standard of need" means the total needs of a group as determined by adding need according to the schedule of living costs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

"Suspension" means a month in which an assistance payment is not made due to ineligibility for one month when eligibility is expected to exist the following month.

"Unborn child" shall include an unborn child during the entire term of the pregnancy.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5, and 239B.6.

441—40.22(239B) Application. The application for the family investment program shall be submitted on the Public Assistance Application, Form 470-0462 or Form 470-0466 (Spanish). Form 470-0462 or Form 470-0466 (Spanish) shall be signed by the applicant, the applicant's authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf. When both parents, or a parent and a stepparent, are in the home, both shall sign the application.

40.22(1) Each individual wishing to do so shall have the opportunity to apply for assistance without delay. When the parent is in the home with the child and is not prevented from acting as payee by reason of physical or mental impairment, this parent shall make the application.

40.22(2) An applicant may be assisted by other individuals in the application process; the client may be accompanied by such individuals in contact with the local office, and when so accompanied, may also be represented by them. When the applicant has a guardian, the guardian shall participate in the application process.

40.22(3) The applicant shall immediately be given an application form to complete. When the applicant requests that the forms be mailed, the local office shall send the necessary forms in the next outgoing mail.

40.22(4) A new application is not required when adding a new person to the eligible group or when a parent or a stepparent becomes a member of the household.

40.22(5) Reinstatement.

a. Assistance shall be reinstated without a new application when all necessary information is provided at least three working days before the effective date of cancellation and eligibility can be reestablished.

b. Assistance may be reinstated without a new application when all necessary information is provided after the third working day but before the effective date of cancellation and eligibility can be reestablished before the effective date of cancellation.

c. When eligibility factors are met, assistance shall be reinstated when a completed Public Assistance Eligibility Report, Form 470-0455 or Form 470-3719(S), or a Review/Recertification Eligibility Document, Form 470-2881, is received by the county office within ten days of the date a cancellation notice is sent to the recipient because the form was incomplete or not returned.

d. Rescinded, effective October 1, 1985.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5 and 239B.6.

441—40.23(239B) Date of application. The date of application is the date an identifiable Public Assistance Application, Form 470-0462 or Form 470-0466 (Spanish), is received in any local or area office or by an income maintenance worker in any satellite office or by a designated worker who is in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The disproportionate share hospital, federally qualified health center or other facility will forward the application to the department office which is responsible for the completion of the eligibility determination. An identifiable application is an application containing a legible name and address that has been signed.

A new application is not required when adding a person to an existing eligible group. This person is considered to be included in the application that established the existing eligible group. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be the date of the report.

In those instances where a person previously excluded from the eligible group as described at 441—subrule 41.27(11) is to be added to the eligible group, the date of application to add the person is the date the person indicated willingness to cooperate.

EXCEPTIONS: When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the date of application to add the person is the date the social security number or proof of application for a social security number is provided.

When adding a person who was previously excluded from the eligible group as described at 441—subrules 41.25(5) and 46.28(2) and rule 441—46.29(239B), the date of application to add the person is the day after the period of ineligibility has ended.

When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.24(8), the date of application to add the person is the date the person signs a family investment agreement.

This rule is intended to implement Iowa Code section 239B.2.

441—40.24(239B) Procedure with application.

40.24(1) The decision with respect to eligibility shall be based primarily on information furnished by the applicant. The applicant shall report no later than at the time of the face-to-face interview any change as defined at 40.27(4)*"e"* which occurs after the application was signed. Any change which occurs after the face-to-face interview shall be reported by the applicant within five days from the date the change occurred.

The county office shall notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or verification, or refusal by the applicant to authorize the county office to secure the information or verification from other sources, shall serve as a basis for denial of assistance. Five working days shall be considered as a reasonable period for the applicant to supply the required information or verification. The county office shall extend the deadline when the applicant requests an extension because the applicant is making every effort to supply the information or verification but is unable to do so. "Supply" shall mean the requested information is received by the department by the specified due date. Any time taken beyond the required time frame shall be considered a delay on the part of the applicant.

a. When an individual is added to an existing eligible group, the five-day requirement for reporting changes shall be waived. These individuals and eligible groups shall be subject to the recipient's ten-day reporting requirement as defined in 40.27(4).

b. Reserved.

40.24(2) In processing an application, the county office or the designated worker as described in rule 441—40.23(239B) who is in a disproportionate share hospital, federally qualified health center, or other facility in which outstationing activities are provided shall conduct at least one face-to-face interview with the applicant prior to approval of the application for assistance. The worker shall assist the applicant, when requested, in providing information needed to determine eligibility and the amount of assistance. The application process shall include a visit, or visits, to the home of the child and the person with whom the child will live during the time assistance is granted under the following circumstances:

a. When it is the judgment of the worker or the supervisor that a home visit is required to clarify or verify information pertaining to the eligibility requirements; or

b. When the applicant requests a home visit for the purpose of completing a pending application.

When adding an individual to an existing eligible group, the face-to-face interview requirement may be waived.

40.24(3) The applicant who is subject to monthly reporting as described in 40.27(1) shall become responsible for completing Form 470-0455 or Form 470-3719(S), Public Assistance Eligibility Report, after the time of the face-to-face interview. This form shall be issued and returned according to the requirements in 40.27(4)*"b."* The application process shall continue as regards the initial two months of eligibility, but eligibility and the amount of payment for the third month and those following are dependent on the proper return of these forms. The county office shall explain to the applicant at the time of the face-to-face interview the applicant's responsibility to complete and return this form.

40.24(4) The decision with respect to eligibility shall be based on the applicant's eligibility or ineligibility on the date the county office enters all eligibility information into the department's computer system, except as described in 40.24(3). The applicant shall become a recipient on the date the county office enters all eligibility information into the department's computer system and the computer system determines the applicant is eligible for aid.

This rule is intended to implement Iowa Code sections 239B.4, 239B.5 and 239B.6.

441—40.25(239B) Time limit for decision. A determination of approval or denial shall be made as soon as possible, but no later than 30 days following the date of filing an application. A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility or ineligibility. This time standard shall apply except in unusual circumstances, such as when the county office and the applicant have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the county office. When eligibility is dependent upon the birth of a child, the time limit may be extended while awaiting the birth of the child. When it becomes evident that due to an error on the part of the county office, eligibility will not be established within the 30-day limit, the application shall be approved pending a determination of eligibility.

This rule is intended to implement Iowa Code sections 239B.3, 239B.4, 239B.5 and 239B.6.

441—40.26(239B) Effective date of grant. New approvals shall be effective as of the date the applicant becomes eligible for assistance, but in no case shall the effective date be earlier than seven days following the date of application. When an individual is added to an existing eligible group, the individual shall be added effective as of the date the individual becomes eligible for assistance, but in no case shall the effective date be earlier than seven days following the date the change is reported. When it is reported that a person is anticipated to enter the home, the effective date of assistance shall be no earlier than the date of entry or seven days following the date of report, whichever is later.

When the change is timely reported as described at subrule 40.27(4), a payment adjustment shall be made when indicated. When the individual's presence is not timely reported as described at subrule 40.27(4), excess assistance issued is subject to recovery.

In those instances where a person previously excluded from the eligible group as described at 441—subrule 41.27(11) is to be added to the eligible group, the effective date of eligibility shall be seven days following the date the person indicated willingness to cooperate. However, in no instance shall the person be added until cooperation has actually occurred.

EXCEPTIONS: When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the effective date of eligibility shall be seven days following the date that the social security number or proof of application for a social security number is provided.

When adding a person who was previously excluded from the eligible group as described at 441—subrules 41.25(5) and 46.28(2) and rule 441—46.29(239B), the effective date of eligibility shall be seven days following the date that the period of ineligibility ended.

When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.24(8), the effective date of eligibility shall be seven days following the date the person signs a family investment agreement. In no case shall the effective date be within the six-month ineligibility period of a subsequent limited benefit plan as described at 441—paragraph 41.24(8)*"a."*

This rule is intended to implement Iowa Code section 239B.3.

441—40.27(239B) Continuing eligibility.

40.27(1) Eligibility factors shall be reviewed at least every six months for the family investment program. A semiannual review shall be conducted using information contained in and verification supplied with Form 470-0455 or Form 470-3719(S), Public Assistance Eligibility Report. A face-to-face interview shall be conducted at least annually at the time of a review using information contained in and verification supplied with Form 470-2881, Review/Recertification Eligibility Document. When the client has completed a Public Assistance Application, Form 470-0462 or Form 470-0466 (Spanish), for another purpose required by the department, this form may be used as the review document for the semiannual or annual review.

a. Any assistance unit with one or more of the following characteristics shall report monthly:

(1) The assistance unit contains any member with earned income, unless the income is either exempt or the only earned income is from annualized self-employment.

(2) The assistance unit contains any member with a recent work history. A recent work history means the person received earned income during either one of the two calendar months immediately preceding the budget month, unless the income was either exempt or the only earned income was from annualized self-employment.

(3) The assistance unit contains any member receiving nonexempt unearned income, the source or amount of which is expected to change more often than once annually, unless the income is from job insurance benefits or interest; or unless the assistance unit's adult members are 60 years old or older, or are receiving disability or blindness payments under Titles I, II, X, XIV, or XVI of the Social Security Act; or unless all adults, who would otherwise be members of the assistance unit, are receiving Supplemental Security Income including state supplementary assistance.

(4) Rescinded IAB 10/13/93, effective 10/1/93.

(5) The assistance unit contains any member residing out of state on a temporary basis.

b. The assistance unit subject to monthly reporting shall complete a Public Assistance Eligibility Report, Form 470-0455 or Form 470-3719(S), for each budget month, unless the assistance unit is required to complete Form 470-2881, Review/Recertification Eligibility Document, for that month. The Public Assistance Eligibility Report shall be signed by the payee, the payee's authorized representative, or, when the payee is incompetent or incapacitated, someone acting responsibly on the payee's behalf. When both parents or a parent and a stepparent are in the home, both shall sign the form.

40.27(2) A redetermination of specific eligibility factors shall be made when:

a. The recipient reports a change in circumstances (for example, a change in income, as defined at rule 441—40.21(239B)), or

b. A change in the recipient's circumstances comes to the attention of a staff member.

40.27(3) Information for semiannual reviews shall be submitted on Form 470-0455 or Form 470-3719(S), Public Assistance Eligibility Report. Information for the annual face-to-face determination interview shall be submitted on Form 470-2881, Review/Recertification Eligibility Document. When the client has completed Form 470-0462 or Form 470-0466 (Spanish), Public Assistance Application, for another purpose, this form may be used as the review document for the semiannual or annual review. The review form shall be signed by the payee, the payee's authorized representative, or, when the payee is incompetent or incapacitated, someone acting responsibly on the payee's behalf. When both parents, or a parent and a stepparent, are in the home, both shall sign the Public Assistance Eligibility Report, the Review/Recertification Eligibility Document, or the Public Assistance Application.

40.27(4) Responsibilities of recipients (including individuals in suspension status). For the purposes of this subrule, recipients shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility and the amount of the family investment program grant.

b. The recipient shall complete Form 470-0455 or Form 470-3719(S), Public Assistance Eligibility Report, or Form 470-2881, Review/Recertification Eligibility Document, when requested by the county office in accordance with these rules. The form shall be supplied as needed to the recipient by the department. The department shall pay the cost of postage to return the form. When the form is issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the county office by the fifth calendar day of the report month. When the form is not issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the county office by the seventh day of the month after the date it is mailed by the department. The county office shall supply the recipient with Form 470-0455 or Form 470-3719(S), Public Assistance Eligibility Report, or Form 470-2881, Review/Recertification Eligibility Document, on request. Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, signed, dated no earlier than the last day of the budget month and accompanied by verification as required in 441—paragraphs 41.27(1)*"i"* and 41.27(2)*"q."*

441—40.28(239B) Referral for investigation. The local office may refer questionable cases to the department of inspections and appeals for further investigation. Referrals shall be made using Form 427-0328, Referral For Front End Investigation.

This rule is intended to implement Iowa Code section 239B.5.

441—40.29(239B) Conversion to the X-PERT system. Rescinded IAB 10/4/00, effective 12/1/00.

These rules are intended to implement Iowa Code chapter 239B.

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CHAPTER 41
GRANTING ASSISTANCE

[Prior to 7/1/83, Social Services[770] Ch 41]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—41.1 to **41.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, Human Services(441—41.1 to 41.9)]

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

41.21(1) *Age.* The family investment program shall be available to a needy child under the age of 18 years without regard to school attendance.

A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month. The family investment program shall also be available to a needy child of 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, as defined in paragraph 41.24(2)*"e,"* and who is reasonably expected to complete the program before reaching the age of 19.

41.21(2) Rescinded, effective June 1, 1988.

41.21(3) *Residing with relative.* The child shall be living in the home of one of the relatives specified in subrule 41.22(3). When an unwed mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

41.21(4) Rescinded, effective July 1, 1980.

41.21(5) *Deprivation of parental care and support.*

a. A child shall be considered as deprived of parental support or care when the parent is out of the home in which the child lives under the following conditions. When these conditions exist, the parent may be absent for any reason, and may have left only recently or some time previously; except that a parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is not considered absent from the home. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States. A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(1) The nature of the absence is such as either to interrupt or to terminate the parent's functioning as a provider of maintenance, physical care, or guidance for the child; and

(2) The known or indefinite duration of the absence precludes relying on the parent to plan for the present support or care of the child.

b. The family investment program is available to a child of unmarried parents the same as to a child of married parents when all eligibility factors are met.

c. A parent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the child. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

(1) The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by a letter from the physician or on Form 470-0447, Report on Incapacity.

(2) When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

(3) A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for family investment program purposes.

(4) Rescinded IAB 6/1/88, effective 8/1/88.

(5) A parent who is considered incapacitated shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

d. When a child is deprived of support or care of a natural parent, the presence of an able-bodied stepparent in the home shall not disqualify a child for assistance, provided that other eligibility factors are met. A stepparent is a person who is the legal spouse of the child's natural or adoptive parent by ceremonial or common law marriage.

This rule is intended to implement Iowa Code sections 239B.1, 239B.2 and 239B.5.

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

41.22(1) Reserved.

41.22(2) Rescinded, effective June 1, 1988.

41.22(3) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father—adoptive father.

Mother—adoptive mother.

Grandfather—grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather—adoptive grandfather.

Grandmother—grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother—adoptive grandmother.

Great-grandfather—great-great-grandfather.

Great-grandmother—great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother—brother-of-half-blood—stepbrother—brother-in-law—adoptive brother.

Sister—sister-of-half-blood—stepsister—sister-in-law—adoptive sister.

Uncle—aunt, of whole or half blood.

Uncle-in-law—aunt-in-law.

Great uncle—great-great-uncle.

Great aunt—great-great-aunt.

First cousins—nephews—nieces.

Second cousins, meaning the son or daughter of one's parent's first cousin.

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

41.22(9) *Claiming good cause.* Each applicant for or recipient of the family investment program who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Prior to requiring cooperation, the county office shall notify the applicant or recipient on Form 470-0169, Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination. One copy of this form shall be given to the applicant or recipient and one copy shall be signed by the applicant or recipient and the worker and filed in the case record.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the family investment program.

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

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

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

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the county office shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. When the applicant or recipient chooses to claim good cause, Form 470-0170 shall be signed and dated by the client and returned to the county office. This form:

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

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

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

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

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

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

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

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

(2) Corroborate the good cause circumstances.

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

41.22(10) *Determination of good cause.* The local office shall determine whether good cause exists for each applicant for or recipient of the family investment program who claims to have good cause.

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

(1) Be in writing.

(2) Contain the local office's findings and basis for determination.

(3) Be entered in the family investment program case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The local office may exceed this time standard only when:

(1) The case record documents that the office needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in 41.22(11).

c. When the local office determines that good cause does not exist:

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

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

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

e. Prior to making a final determination of good cause for refusing to cooperate, the local office shall:

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

(2) Consider any recommendation from the child support recovery unit.

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

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

h. The local office shall:

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

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

41.22(11) *Proof of good cause.* The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the local office determines the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the local office shall allow a reasonable additional period of time upon approval by the worker's immediate supervisor.

b. When an individual is out of the home to secure education or training, as defined for children in 41.24(2)*"e"* and for adults in 441—subrule 93.114(1), first sentence, as long as the caretaker relative retains supervision of the child.

c. An individual is out of the home for reasons other than reasons in paragraphs *"a"* and *"b"* and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual's needs being removed from the grant.

41.23(4) *Citizenship and alienage for persons entering the United States before August 22, 1996.* Rescinded IAB 10/4/00, effective 12/1/00.

41.23(5) *Citizenship and alienage.*

a. A family investment program assistance grant may include the needs of a citizen or national of the United States, or a qualified alien as defined at 8 United States Code Section 1641. A person who is a qualified alien as defined at 8 United States Code Section 1641 is not eligible for family investment program assistance for five years. The five-year period of ineligibility begins on the date of the person's entry into the United States with a qualified alien status as defined at 8 United States Code Section 1641.

EXCEPTIONS: The five-year prohibition from family investment program assistance does not apply to qualified aliens described in 8 United States Code Section 1612, or to qualified aliens as defined at 8 United States Code Section 1641 who entered the United States before August 22, 1996. A person who is not a United States citizen or is not a qualified alien as defined at 8 United States Code Section 1641 is not eligible for the family investment program regardless of the date the person entered the United States.

b. As a condition of eligibility each recipient shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the recipient's citizenship or alien status, when the statement has not previously been signed on the application. The form shall be signed by the recipient, or when the recipient is incompetent or incapacitated, someone acting responsibly on the recipient's behalf. When both parents are in the home, both shall sign the form. An adult recipient shall sign the form for dependent children. Failure to sign Form 470-2549 when required to do so creates ineligibility for the entire eligibility group.

This rule is intended to implement Iowa Code section 239B.2.

441—41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program. An application for assistance constitutes a registration for the program for all members of the family investment program (FIP) case. Persons in any FIP case who are not exempt from referral to PROMISE JOBS shall enter into a family investment agreement (FIA) as a condition of receiving FIP, except as described at 41.24(8).

41.24(1) *Referral to PROMISE JOBS.*

a. All persons whose needs are included in a grant under the FIP program shall be referred to PROMISE JOBS as FIA-responsible persons unless the county office determines the persons are exempt.

b. Any parent living in the home of a child receiving a grant shall also be referred to PROMISE JOBS as an FIA-responsible person unless the county office determines the person is exempt.

c. Except for persons described at paragraph 41.24(2)*"f,"* persons determined exempt from referral, including applicants, may volunteer for PROMISE JOBS.

d. Applicants who have chosen and are in a limited benefit plan that began on or after June 1, 1999, shall complete significant contact with or action in regard to PROMISE JOBS as described at paragraphs 41.24(8)*"a"* and *"d"* for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent meets the exemption criteria described at subrule 41.24(2).

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

a. and *b.* Rescinded IAB 12/3/97, effective 2/1/98.

c. A person who is under the age of 16 and is not a parent.

d. A person who is disabled, according to the Americans with Disabilities Act, and unable to participate. Medical evidence of disability may be obtained from either an independent physician or psychologist or the state rehabilitation agency in the same manner specified in 41.21(5)*"c."*

e. A person who is aged 16 to 19, and is not a parent, who attends an elementary, secondary or equivalent level of vocational or technical school full-time.

(1) A person shall be considered to be attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A person shall also be considered to be in regular attendance in months when the person is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a person's education is temporarily interrupted pending adjustment of the education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

f. A person who is not a United States citizen and is not a qualified alien as defined in 8 United States Code Section 1641.

41.24(3) *Parents aged 19 and under.*

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

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

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

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

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

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

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

41.24(4) *Method of referral.*

a. While the eligibility decision is pending, applicants in a limited benefit plan that began on or after June 1, 1999, shall receive a letter which contains information about the need to complete significant contact with or action in regard to the PROMISE JOBS program to be eligible for FIP assistance and the procedure for being referred to the PROMISE JOBS program.

b. When the FIP application is approved or when exempt status is lost, volunteers and persons who are not exempt from referral to PROMISE JOBS shall receive a letter which contains information about participant responsibility under PROMISE JOBS and the FIA and instructs the FIP participant to contact PROMISE JOBS within ten calendar days to schedule the PROMISE JOBS orientation.

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

41.24(6) *Volunteers.* Except for persons described at paragraph 41.24(2)*"f,"* any applicant and any recipient may volunteer for referral. The income maintenance worker shall not refer an applicant to the program when it appears that the applicant shall be ineligible for FIP.

41.24(7) *Referral to vocational rehabilitation.* The department shall make the department of education, division of vocational rehabilitation services, aware of any person determined exempt from referral to PROMISE JOBS because of a medically determined physical or mental impairment. However, acceptance of vocational rehabilitation services by the client is optional.

41.24(8) *The limited benefit plan (LBP).* When a participant responsible for signing and meeting the terms of a family investment agreement as described at rule 441—93.109(239B) chooses not to sign or fulfill the terms of the agreement, the FIP eligible group or the individual participant shall enter into a limited benefit plan. The first month of the limited benefit plan is the first month after the month in which timely and adequate notice is given to the participant as defined at 441—subrule 7.7(1). A participant who is exempt from PROMISE JOBS is not subject to the limited benefit plan.

a. A limited benefit plan shall either be a first limited benefit plan or a subsequent limited benefit plan. From the effective date of the limited benefit plan, for a first limited benefit plan, the FIP household shall not be eligible until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph *"d."* If a subsequent limited benefit plan is chosen by the same participant, a six-month period of ineligibility applies and ineligibility continues after the six-month period is over until the participant who chose the LBP completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph *"d."* A limited benefit plan imposed in error as described in paragraph *"f"* shall not be considered a limited benefit plan. A limited benefit plan is considered imposed when timely and adequate notice is issued establishing the limited benefit plan.

b. The limited benefit plan shall be applied to participants responsible for the family investment agreement and other members of the participant's family as follows:

(1) When the participant responsible for the family investment agreement is a parent or needy caretaker relative, the limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1).

(2) When the participant choosing a limited benefit plan is a needy relative who acts as payee when the parent is in the home but is unable to act as payee, or is a dependent child's stepparent who is in the FIP eligible group because of incapacity or caregiving, the limited benefit plan shall apply only to the individual participant choosing the plan.

(3) When the FIP eligible group includes a minor parent living with the minor parent's adult parent or needy caretaker relative who receives FIP benefits and both the minor parent and the adult parent or needy caretaker relative are responsible for developing a family investment agreement, each parent or needy caretaker relative is responsible for a separate family investment agreement, and the limited benefit plan shall be applied as follows:

1. When the adult parent or needy caretaker relative chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the entire eligible group, even though the minor parent has not chosen the limited benefit plan. However, the minor parent may reapply for FIP benefits as a minor parent living with self-supporting parents or as a minor parent living independently and continue in the family investment agreement process.

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

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

(4) When the FIP eligible group includes children who are mandatory PROMISE JOBS participants, the children shall not have a separate family investment agreement but shall be asked to sign the eligible group's family investment agreement and to carry out the responsibilities of that family investment agreement. A limited benefit plan shall be applied as follows:

1. When the parent or needy caretaker relative responsible for a family investment agreement meets those responsibilities but a child who is a mandatory PROMISE JOBS participant chooses an individual limited benefit plan, the limited benefit plan shall apply only to the individual child choosing the plan.

2. When the child who chooses a limited benefit plan under numbered paragraph "1" above is the only child in the eligible group, the parents' or needy caretaker relative's eligibility ceases in accordance with subrule 41.28(1). The parents or needy caretaker relative shall become ineligible beginning with the effective date of the child's limited benefit plan.

41.25(6) *Aliens sponsored by an agency or organization.* Rescinded IAB 10/4/00, effective 12/1/00.

41.25(7) *Time limit for receiving assistance.*

a. Assistance shall not be provided to a FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under any state program in Iowa or in another state that is funded by the Temporary Assistance for Needy Families (TANF) block grant. The 60-month period need not be consecutive. An "adult" is any person who is a parent of the FIP child in the home, or included as an optional member under subparagraphs 41.28(1)*"b"*(1), (2) and (3). In two-parent households, the 60-month limit is determined when either parent has received assistance for 60 months. "Assistance" shall include any month for which the adult receives a FIP grant. Assistance received for a partial month shall count as a full month.

b. In determining the number of months an adult received assistance, the department shall consider toward the 60-month limit:

(1) Assistance received even when the parent is excluded from the grant unless the parent is an SSI recipient.

(2) Assistance received by an optional member of the eligible group as described in subparagraphs 41.28(1)*"b"*(1) and (2). However, once the person has received assistance for 60 months, the person is ineligible but assistance may continue for other persons in the eligible group. The entire family is ineligible for assistance when the optional member who has received assistance for 60 months is the incapacitated stepparent on the grant as described at subparagraph 41.28(1)*"b"*(3).

c. In determining the number of months an adult received assistance, the department shall not consider toward the 60-month limit any month for which FIP assistance was not issued for the family, such as:

(1) A month of suspension.

(2) A month for which no grant is issued due to the limitations described in rules 441—45.26(239B) and 441—45.27(239B).

(3) When all assistance for the month is returned.

(4) When all assistance for the month is reimbursed via child support collection or overpayment recovery.

d. The department shall not consider toward the 60-month limit months of assistance a parent or pregnant person received as a minor child and not as the head of a household or married to the head of a household. This includes assistance received for a minor parent for any month in which the minor parent was a child on the adult parent's FIP case or on the nonparental caretaker's FIP case.

e. The department shall not consider toward the 60-month limit months of assistance received by an adult while living in Indian country (as defined in 18 United States Code Section 1151) or a Native Alaskan village where at least 50 percent of the adults were not employed.

This rule is intended to implement Iowa Code sections 239B.2 and 239B.5.

41.25(8) *School attendance requirements.*

a. The department shall require an applicant for or recipient of family investment program assistance who is the child's parent in the home or other specified relative whose needs are included in the grant payable to the child's family to cooperate with efforts to ensure children receiving family investment program assistance complete educational requirements through the sixth grade. As a condition of eligibility, an applicant or recipient, who is the child's parent in the home or specified relative whose needs are included in the FIP grant, shall provide written authorization for release of information to a school truancy officer concerning the receipt of assistance and for release of information by a school truancy officer concerning the child's compliance with attendance requirements on Form 470-3383, Authorization to Exchange Information With Your Child's School.

A signed authorization is required for any child in the home aged 5 through 13 who is a member of the FIP eligible group. The same signed authorization shall cover all FIP children in the home who are aged 5 through 13 on the date the release is signed. An additional signed release is required when a FIP child turns the age of 5 after the date a release was signed or when another child aged 5 through 13 joins the FIP eligible group after the date the release was signed. Signed releases obtained by the department from July 1, 1997, to December 1, 1997, remain in effect for all FIP children aged 5 through 13 who were in the home when the release was received by the county department office.

When both parents are in the home, both shall sign the release. When a minor parent and the minor's child receive family investment program assistance on the adult parent's case, or on the case of a specified relative whose needs are included in the assistance grant, the adult parent or specified relative shall sign the release. The signed release shall stay in effect until the FIP child turns 14 years of age. A new release is required when the household reapplies for family investment program and a new application is needed to determine the household's eligibility. Assistance shall be denied or canceled when the household fails to supply a signed release within the time frames described at 441—subrules 40.24(1) and 40.27(4). However, FIP assistance shall not be denied or canceled prior to January 1, 1998, for failure to return a signed release. The requirements in this paragraph apply to children in a public school or an accredited nonpublic school who have not completed sixth grade. They do not apply to children who are receiving competent private instruction in accordance with Iowa Code chapter 299A.

b. If a child of a family applying for or receiving family investment program assistance is not in compliance with the attendance requirements established under Iowa Code section 299.1, and has not completed educational requirements through the sixth grade, and the school has used every means available to ensure the child does attend, the truancy officer, as defined at Iowa Code section 299.12, shall provide written notification to the department. The department shall then initiate contact with the child's parent or other specified relative to participate in an attendance cooperation meeting. The parties to the attendance cooperation meeting may include the child, and shall include the child's parent in the home or specified relative whose needs are included in the child's assistance grant, the truancy officer and a representative of the department. When both parents of the child live in the child's home, both shall be encouraged to attend, but only one parent is required to attend. The department's representative or the truancy officer may invite other parties deemed appropriate to participate in the attendance cooperation meeting, such as other school officials, the county attorney or designee, or a designee of the juvenile court. The family may also invite another family member, a friend, advocate, or legal representative to the meeting.

c. The purpose of the attendance cooperation meeting is for the participating parties to attempt to ascertain the cause of the child's nonattendance, to cause the parties to arrive at an agreement addressing the child's attendance, and to initiate referrals to any services or counseling that the parties believe to be appropriate under the circumstances. The terms agreed to shall be reduced to writing in Form 470-3391, School Attendance Cooperation Agreement, and signed by the parties to the agreement. In two-parent families, both parents shall sign the agreement even if only one parent attends the meeting. Each party signing the agreement shall receive a copy of the agreement, which shall set forth the cause identified for the child's nonattendance and future responsibilities of each party.

d. If the parties to an attendance cooperation meeting determine that a monitor would improve compliance with the attendance cooperation agreement, the parties may designate a person to monitor the agreement. The monitor shall be a designee of the department. The monitor may be a volunteer if the volunteer is approved by all parties to the agreement and receives a written authorization for access to confidential information and for performing monitor activities from the child's parent or specified relative. A monitor shall contact parties to the attendance cooperation agreement on a periodic basis as appropriate to monitor the performance of the agreement.

e. If the parties fail to enter into an attendance cooperation agreement, or the child's parent or specified relative acting as a party violates a term of the attendance cooperation agreement or fails to participate in an attendance cooperation meeting without good cause, and the truancy officer confirms that the child still meets the conditions for being deemed truant, then the child shall be deemed to be truant.

The parent or specified relative shall be considered to have good cause when failing to attend the meeting for reasons beyond the person's control, such as illness, family emergencies or other unforeseen circumstances.

f. If the department receives written notification from a school truancy officer under Iowa Code section 299.12 that a child receiving family investment program assistance is deemed to be truant, the child's family shall be subject to sanction as provided in paragraph *"g."* The sanction shall continue to apply until the department receives written notification from the school truancy officer of any of the following:

(1) The child is complying with the attendance policy applicable to the child's school.

(2) The child has satisfactorily completed educational requirements through the sixth grade.

(3) The child's school has determined there is good cause for the child's nonattendance and the school withdraws the written notification.

(4) The child is no longer enrolled in the school for which the written notification was provided and the child's family demonstrates that the child is enrolled in and is attending another school or is otherwise receiving equivalent schooling as authorized under state law.

g. The sanction shall be a deduction of 25 percent from the net cash assistance grant amount payable to the child's family prior to any deduction for recoupment of a prior overpayment. If more than one child is deemed to be truant, the sanction shall continue to apply until the department receives written notification from the school truancy officer, as described in paragraph *"f,"* concerning each child. When the family is also subject to sanction under paragraph 41.22(6)*"f,"* the sanction for truancy shall be calculated as though the sanction in paragraph 41.22(6)*"f"* does not exist.

41.25(9) *Pilot diversion programs.* Assistance shall not be approved when an assistance unit is subject to a period of ineligibility as described at 441—Chapter 47.

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

This rule is intended to implement Iowa Code chapters 239B and 299.

441—41.26(239B) Resources.

41.26(1) *Limitation.* An applicant or recipient may have the following resources and be eligible for the family investment program. Any resource not specifically exempted shall be counted toward resource limitations.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at 41.26(1)*"n"* or *"o"* and 41.26(6)*"d,"* the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

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

d. An equity not to exceed a value of $3000 in one motor vehicle for each adult and working teenage child whose resources must be considered as described in 41.26(2). The disregard shall be allowed when the working teenager is temporarily absent from work. The equity value in excess of $3000 of any vehicle shall be counted toward the resource limitation in 41.26(1)*"e."* When a motor vehicle(s) is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle(s).

Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2000 for applicant assistance units and $5000 for recipient assistance units. EXCEPTION: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the $5000 limit. The exception includes those persons who did not receive an assistance grant due to the limitations described at rules 441—45.26(239B) and 45.27(239B) and persons whose grants were suspended as in 41.27(9)*"f"* in the month prior to the month of application.

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

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

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

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

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Earned income credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in computing whether the eligible group's property is within the reserve defined in paragraph *"e."*

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

41.26(2) *Persons considered.*

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

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

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

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

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

f. and *g.* Rescinded IAB 10/4/00, effective 12/1/00.

41.26(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½-acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 41.26(5).

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

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

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

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

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

41.26(6) *Availability.*

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

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

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

b. Rescinded IAB 6/30/99, effective 9/1/99.

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

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

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

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant/recipient the month following the month the payment was received. When the applicant/recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

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

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

b. When the local office questions whether the funds in a trust or conservatorship are available, the local office shall refer the trust or conservatorship to central office. When assets in the trust or conservatorship are not clearly available, central office staff may contact the trustee or conservator and request that the funds in the trust or conservatorship be made available for current support and maintenance. When the trustee or conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments. Funds in a trust or conservatorship that are not clearly available shall be considered unavailable until the trustee, conservator or court actually makes the funds available. Payments received from the trust or conservatorship for basic or special needs are considered income.

41.26(9) *Aliens sponsored by individuals.* Rescinded IAB 10/4/00, effective 12/1/00.

41.26(10) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, and inventory or supplies retained by the household shall not be considered a resource.

This rule is intended to implement Iowa Code section 239B.5.

441—41.27(239B) Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered in determining initial and continuing eligibility and the amount of the family investment program grant. The determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income, exclusive of the family investment program grant, received by the eligible group and available to meet the current month's needs is no more than 185 percent of the standard of need for the eligible group; (2) the countable net unearned and earned income is less than the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard for the eligible group. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the standard of need for the eligible group; and (2) countable net unearned and earned income is less than the payment standard for the eligible group. The amount of the family investment program grant shall be determined by subtracting countable net income from the payment standard for the eligible group. Child support assigned to the department in accordance with subrule 41.22(7) and retained by the department as described in subparagraph 41.27(1)*"h"*(2) shall be considered as exempt income for the purpose of determining continuing eligibility, including child support as specified in paragraph 41.27(7)*"q."* Deductions and diversions shall be allowed when verification is provided. The county office shall return all verification to the applicant or recipient.

41.27(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (federal insurance contribution Act, state and federal income taxes). Net unearned income, from investment and nonrecurring lump sum payments, shall be determined by deducting reasonable income producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Rescinded, effective December 1, 1986.

c. Rescinded, effective September 1, 1980.

d. Rescinded IAB 2/11/98, effective 2/1/98.

e. Rescinded IAB 2/11/98, effective 2/1/98.

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

g. Every person in the eligible group shall apply for benefits for which that person may be qualified and accept those benefits, even though the benefit may be reduced because of the laws governing a particular benefit. The needs of any individual who refuses to cooperate in applying for or accepting benefits from other sources shall be removed from the eligible group. The individual is eligible for the 50 percent work incentive deduction in paragraph 41.27(2)*"c."*

h. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment for a member of the eligible group, made while the application is pending, shall be treated as unearned income and deducted from the initial assistance grant(s). Any cash support payment for a member of the eligible group, except as described at 41.27(7)*"p"* and *"q,"* received by the recipient after the date of decision as defined in 441—subrule 40.24(4) shall be refunded to the child support recovery unit.

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

(3) and (4) Rescinded IAB 12/3/97, effective 2/1/98.

i. The applicant or recipient shall cooperate in supplying verification of all unearned income, as defined at rule 441—40.21(239B). When the information is available, the county office shall verify job insurance benefits by using information supplied to the department by the department of workforce development. When the county office uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day. When the client notifies the county office that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A payment adjustment shall be made when indicated. Recoupment shall be made for any overpayment. The client must report the discrepancy prior to the payment month or within ten days of the date on the Notice of Decision, Form 470-0485(C) or 470-0486(M), applicable to the payment month, whichever is later, in order to receive a payment adjustment.

j. Every person in the eligible group shall apply for and accept health or medical insurance when it is available at no cost to the applicant or recipient, or when the cost is paid by a third party, including the department of human services. The needs of any individual who refuses to cooperate in applying for or accepting this insurance shall be removed from the eligible group. The individual is eligible for the 50 percent work incentive deduction in paragraph 41.27(2)*"c."*

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

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, is considered in determining eligibility and the amount of the assistance grant is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include all work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Rescinded IAB 12/29/99, effective 3/1/00.

ac. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

ad. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

ae. Interest and dividend income.

af. Rescinded IAB 12/3/97, effective 2/1/98.

ag. Terminated income of recipient households who are subject to retrospective budgeting beginning with the calendar month the source of the income is absent, provided the absence of the income is timely reported as described at 441—subrule 40.24(1) and 441—subparagraph 40.27(4)*"f"*(1).

EXCEPTION: Income that terminated in one of the two initial months occurring at time of an initial application that was not used prospectively shall be considered retrospectively as required by 41.27(9)*"b"*(1). If income terminated and is timely reported but a grant adjustment cannot be made effective the first of the next month, a payment adjustment shall be made. This subrule shall not apply to nonrecurring lump sum income defined at 41.27(9)*"c"*(2).

ah. Welfare reform and regular household honorarium income. All moneys paid to a FIP household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ai. Diversion or self-sufficiency grants assistance as described at 441—Chapter 47.

aj. Payments from property sold under an installment contract as specified in paragraphs 41.26(4)*"b"* and 41.27(1)*"f."*

ak. All census earnings received by temporary workers from the Bureau of the Census for Census 2000 during the period of April 1, 2000, through January 31, 2001.

41.27(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases.

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the 20 percent earned income deduction, the 50 percent work incentive deduction described at 41.27(2)*"a"* and *"c,"* and diversions described at 41.27(4), and shall be permitted to retain that part of the parent's income to meet the parent's needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described at 41.27(11). All remaining income of the parent shall be applied against the needs of the eligible group.

(2) Rescinded IAB 10/4/00, effective 12/1/00.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group, but is living with the parent in the home of the eligible child(ren), shall be given the same consideration and treatment as that of a natural parent subject to the limitations of subparagraphs (1) to (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) Rescinded IAB 6/30/99, effective 7/1/99.

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at 41.27(11), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions in 41.27(8)*"b"*(1) to (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the family investment program standard of need for a family group of the same composition.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3), (4), and (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3), (4) and (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, and after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the local office shall recompute the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

j. Special needs.

(1) A special need as defined in 41.28(3) must be documented before payment shall be made.

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system, except as specified in subparagraph (5) below.

(3) An ongoing special need is considered in determining need for the calendar month following the calendar month in which the special need is entered on the automated benefit calculation system.

(4) When the special need continues, payment shall be included, prospectively, in each month's family investment program grant. When the special need ends, payment shall be removed prospectively. Any overpayment for a special need shall be recouped.

(5) Any documentation of a special need received during a month of suspension shall be considered in determining eligibility and the amount of payment for the month following the month of suspension.

k. When a family's assistance for a month is subject to recoupment because the family was not eligible, individuals applying for assistance during the same month may be eligible for the family investment program as a separate eligible group. Income of this new eligible group plus income of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant. The income of an ineligible parent or other legally responsible person shall be considered prospectively in accordance with 41.27(4) and 41.27(8).

41.27(10) *Aliens sponsored by individuals.* Rescinded IAB 10/4/00, effective 12/1/00.

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CHAPTER 42
UNEMPLOYED PARENT

[Prior to 7/1/83, Social Services [770] Ch 42]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—42.1 to **42.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, 441—42.1(239) to 42.8(239)]

441—42.21(239B) Definitions.

"Bona fide offer" means an actual or genuine offer which includes a specific wage or a training opportunity at a specific place when used to determine whether the parent has refused an offer of training or employment.

"Parent" means the natural or adoptive parent.

441—42.22(239B) Deprivation. A child shall be eligible for assistance on the basis of being deprived of parental care or support by reason of both parents being considered unemployed as described in rules 441—42.24(239B) and 441—42.25(239B). If either parent cannot be considered unemployed, then deprivation on the basis of unemployment does not exist.

42.22(1) Priority of other deprivation factors. When deprivation exists because of parental absence or incapacity, that deprivation factor supersedes and the case shall not be processed on the basis of a parent's unemployment.

42.22(2) Reserved.

441—42.23(239) Principal earner. Rescinded IAB 10/13/93, effective 10/1/93.

441—42.24(239B) Eligibility. When both parents of a common child are in the home and neither parent is incapacitated as defined at 441—subrule 41.21(5), eligibility for assistance shall be determined under the unemployed parent program, without regard to either parent's hours of employment, income or resources. For the purpose of determining eligibility and benefit amount, the filing unit shall include the common child, any parent and any deprived sibling of the common child living in the home with the common child as described at 441—subrule 41.28(1). Each parent in an unemployed parent case shall meet the following requirements:

42.24(1) When both parents are unemployed as defined, the effective date for unemployed parent assistance shall be established in accordance with rule 441—40.26(239B).

a. Rescinded IAB 12/3/97, effective 2/1/98.

b. The parent who is an applicant who is out of work due to refusal without good cause of a bona fide offer of employment or training for employment shall not be considered unemployed. The parent who is a recipient who is out of work due to refusal without good cause of a bona fide offer of employment or training shall be subject to 42.24(4).

c. The parent who is out of work due to a labor dispute shall not be considered unemployed.

d. All parents are automatically registered for work under the provisions of rule 441—41.24(239B) and subrule 41.22(14). Unless determined exempt, both parents shall be referred to the PROMISE JOBS program. In addition, while the application is pending, or while an existing eligible group is being redetermined for eligibility under the unemployed parent program, both parents shall cooperate in being referred to work by taking Form PA-2138-5, Unemployed Parent Referral to Employment Services, to the department of workforce development. Both parents shall apply for and receive job insurance benefits when eligible. When either parent fails to cooperate in the referral to the department of workforce development or refuses to apply for or draw unemployment benefits, there is no eligibility on the basis of unemployment.

e. Notwithstanding any other provision of this subrule, while the application is pending, or while an existing eligible group is being redetermined for eligibility under the unemployed parent program, the parent shall cooperate with the department of workforce development in actively searching for employment or training for employment, unless the parent is participating in a training plan or personally providing care to a child under three months of age. Either parent who fails or refuses to cooperate with the department of workforce development without good cause, as defined in 42.24(3), shall not be considered unemployed.

42.24(2) Failure to cooperate. A parent shall not, without good cause, end, limit, or reduce hours of employment; refuse job search assistance or counseling when a counselor is assigned from workforce development; or refuse a bona fide offer of employment or training for employment. Failure to follow up on a job or training referral shall be considered the same as a refusal.

When either parent who is an applicant fails to cooperate, the parent is not considered to be unemployed. The needs of any person in the eligible group whose eligibility is dependent on either parent's unemployment shall not be included in the assistance grant. When the parent is a recipient, then the eligible group is subject to 42.24(4).

42.24(3) Establishing good cause.

a. When a bona fide offer of employment or training is made independently of the PROMISE JOBS program, the determination of whether or not there was good cause for refusal is an income maintenance responsibility.

b. Good cause for limiting or reducing hours, ending or refusing a bona fide offer of employment or training exists when any of the problems with participation of a temporary or incidental nature specified in rule 441—93.133(239B) are identified or barriers to participation as described at rule 441—93.134(239B) are identified.

c. When an offer of employment or training is through the PROMISE JOBS program, the determination as to whether the offer is bona fide, or whether there is good cause to refuse it, shall be made by PROMISE JOBS program staff who shall initiate the limited benefit plan as described at 441—subrule 41.24(8). Any appeal from a mandatory referral shall be directed to the department.

42.24(4) Relationship with the PROMISE JOBS program. Unless determined exempt, both parents shall be referred to and shall be required to participate in the PROMISE JOBS program. Any parent may volunteer for the program.

The policies of the family investment agreement (FIA) described at rule 441—93.109(239B) and the family investment program-unemployed parent work program described at rule 441—93.122(239B) are applicable to both parents. When FIA-responsible persons choose not to sign the FIA or choose not to meet the responsibilities of the FIA, the household has chosen the limited benefit plan, as described at 441—subrule 41.24(8).

441—42.25(239B) Not considered unemployed. After assistance is approved, when either parent is no longer considered unemployed, in accordance with paragraph 42.24(1)*"c"* or because of failure to apply for or draw job insurance benefits, eligibility for unemployed parent assistance no longer exists for those persons whose eligibility is dependent on the unemployment of both parents.

441—42.26(239) Inclusion of the nonqualifying parent. Rescinded IAB 10/13/93, effective 10/1/93.

441—42.27(239) Income maintenance worker contact to ensure active search for employment or training. Rescinded IAB 10/13/93, effective 10/1/93.

441—42.28(239B) Assistance continued. An adjustment period following the incapacitated parent's recovery or the absent parent's return home shall continue for only as long as is necessary to determine whether there is eligibility on the basis of parental unemployment. When deprivation on the basis of unemployment cannot be established, assistance shall be continued for a maximum of three monthly grants.

These rules are intended to implement Iowa Code section 239B.2.

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◊Two or more ARCs

CHAPTER 43
ALTERNATE PAYEES

[Prior to 7/1/83, Social Services[770] Ch 43]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—43.1 to 43.20 Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, 441—43.1(239) to 43.4(239)]

441—43.21(239B) Conservatorship or guardianship.

43.21(1) When application is filed for the family investment program by a person under conservatorship or guardianship, a copy of the court order shall be secured by the local office. Assistance payments shall be made to the conservator or guardian to be allocated for the support and care of the dependent child.

43.21(2) The department may petition the probate court to appoint a conservator over any payee when the department has reason to believe any payments of the family investment program are not being used or may not be used in the best interests of the child. Assistance payments shall be made to the conservator to be allocated for the support and care of the dependent child(ren).

441—43.22(239B) Protective payments.

43.22(1) Protective payments shall be made to a protective payee when a recipient has demonstrated severe difficulties in managing money, but has the capacity to learn, in a relatively short time, to manage funds in a reasonably adequate manner. Protective payments shall be utilized in the following instances:

a. When the family investment program payee has clearly demonstrated such inability to manage funds that the needs of the children have not been reasonably served.

b. Rescinded IAB 12/8/93, effective 1/1/94.

c. Rescinded IAB 12/3/97, effective 3/1/98.

43.22(2) Consideration shall be given to the appointment of a protective payee when there is clear and specific evidence that the family investment program payee persistently mismanages the assistance payments to the detriment of the children. This evidence includes, but is not limited to:

a. Continued refusal or inability to properly feed and clothe the dependent children.

b. Continued expenditures made for nonessentials or for other items so as to threaten the children's chances for healthy growth and development.

c. Continued, persistent, and deliberate failure to meet obligations for rent, food, school supplies, or other essentials.

d. Repeated evictions or incurrence of debts with attachments or levies made against current income.

e. Continued inability to plan and spread necessary expenditures over the usual period between assistance grants.

43.22(3) The local office has the responsibility for determining whether to recommend a protective payee, in selecting the payee, recommending termination of the arrangement, and providing casework services directed toward increasing money management skills of the recipient.

43.22(4) The selection and appointment of a protective payee shall be in accordance with the following standards.

a. Interest in and concern with the well-being of the recipient family. This interest may have been demonstrated by regular and frequent visits to the family or past efforts to help the family at time of crisis.

b. Interest, ability, and the time to help the family to make proper use of the assistance payment in connection with ordinary household budgeting. This ability may have been demonstrated by past experience in purchasing food and clothing and household supplies within a restricted income or other knowledge of effective household money management practices.

c. Geographical proximity or means of transportation to the family to be accessible for frequent consultation on household budgeting and other household money payment problems.

d. Ability to establish and maintain positive relationships with members of the family. The protective payee must assume a teaching role to facilitate the acquisition of new money management skills.

e. A responsible, dependable, and reliable individual with the capacity to handle highly confidential family information and to handle money which is vital and essential to another family's daily well-being.

f. Not an individual with a direct or indirect interest in the disposition of the assistance payment, such as the executive officer of the agency, landlord, grocer, or other vendor of goods and services dealing with the recipient.

g. Not an employee of the local office.

43.22(5) The protective payee shall manage or supervise and make basic decisions about the expenditure of the assistance payment. As the recipient demonstrates the ability to use the funds appropriately, the protective payee shall gradually increase self-management until the recipient is able to manage the entire assistance payment. The protective payee shall make a quarterly report to the local office of general expenditures and progress being made by the recipient in money management within 30 days following the end of each three-month period.

43.22(6) A protective payment arrangement for persons specified in paragraph 43.22(1)*"a"* shall be limited to 12 months.

43.22(7) All protective payment arrangements shall be evaluated at least every three months to determine whether the protective payee is carrying out the responsibilities in the best interests of the child or children. In addition, a decision shall be made for each protective payment arrangement for persons specified in paragraph 43.22(1)*"a"* whether to:

a. Restore the recipient to regular money payment status,

b. Continue the recipient under protective payment status, or

c. Arrange for the appointment of a conservator when it appears that the recipient is unable to respond to the beneficial effects of the protective payment plan or progress is so slow as to require continuation of the plan beyond the time limitation on protective payments.

43.22(8) Protective payments for persons specified in paragraph 43.22(1)*"a"* shall be limited to 10 percent of the total family investment program caseload.

441—43.23(239B) Vendor payments.

43.23(1) A vendor payment or payments may be made in an emergency situation when the recipient has become so involved financially that proper care for the family may be secured only with a guarantee of payment from the department. A vendor payment or payments may be made upon the request of the recipient or when the local office determines it is necessary to extricate the family from financial difficulties or to comply with the provisions of the work incentive program. Emergency situations include, but are not limited to:

a. Eviction and inability to find other shelter.

b. Termination of or refusal to provide utilities by the utility company.

c. The necessity to provide such essentials as food, clothing, and shelter for dependent children.

d. Continued inability on the part of the payee to manage funds for the benefit of the family, but time is needed to secure a protective payee or a conservator or guardian.

43.23(2) Vendor payments shall be authorized subject to the following limitations:

a. Vendor payments shall be authorized only by the local administrator.

b. Vendor payments shall be authorized only with the knowledge and consent of the recipient except in those instances where the vendor payment provision is utilized on an emergency basis to protect the family pending the completion of other arrangements.

c. Vendor payments shall be authorized only to meet emergent situations which limit the recipient's ability to furnish care for children.

d. Vendor payments shall be authorized monthly. When the payments are needed for a period in excess of two months, approval shall be granted by the district income maintenance supervisor or designee.

e. Vendor payments shall be a part of the limitation specified in subrule 43.22(8).

43.23(3) The amount of vendor payment shall be established in the following manner:

a. A vendor payment or payments shall be for a specific item or items of need.

b. The recipient, worker, and vendor shall mutually agree upon the quantity, kinds, and quality of goods or services to be provided and the amount to be paid, except in those instances where the vendor payment is necessary as described in subrule 43.23(1) without the consent of the payee.

c. The entire item of need established in 43.23(3)*"a"* shall be covered by the vendor payment except in those instances where the family investment program grant is less than the amount needed for the vendor payment. In these instances the amount of the vendor payment shall not exceed the amount of the assistance grant.

d. Before a vendor payment is established, consideration shall be given to the family's entire financial situation so that the vendor payment will not jeopardize the funds needed for the family's other expenses.

e. When a vendor payment is established because of a recipient's failure to participate in the work incentive program, such payment shall be 50 percent or more of the total assistance paid for the month.

f. The balance of the assistance payment not used for the vendor payment shall be paid to the recipient.

43.23(4) The county office shall send the vendor two copies of Form 470-0493, Authorization for FIP Vendor Payment. The vendor shall complete and return one copy of the form to the county office along with a copy of the billing, invoice or statement.

441—43.24(239B) Emergency payee. Payments may be made to persons acting for relatives who have been receiving assistance for a child in emergency situations that deprive the child of the relatives' care. These payments shall be made for a temporary period, not to exceed three months, to allow time to make and implement plans for the child's continuing care and support.

These rules are intended to implement Iowa Code section 239B.13.

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CHAPTER 45
PAYMENT

[Ch 45, January 1974 IDR Supplement, renumbered as [770] Ch 42]
[Prior to 7/1/83, Social Services[770] Ch 45]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—45.1 to **45.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, 441—45.1(239) to 45.7(239)]

441—45.21(239B) Address. Assistance warrants shall be mailed to the recipient's current address or, upon request, to a post office box, bank, or to any other address for which the recipient has good reason for the request. Assistance warrants shall be mailed to the protective payee, conservator, or guardian (if applicable) in cases involving said persons. Assistance shall also be paid by direct deposit to the recipient's own account in a financial institution or by means of electronic benefits transfer.

441—45.22(239B) Return. Assistance warrants are not forwardable. When they cannot be delivered by the post office, they shall be returned to either the local office or to the central office.

441—45.23(239B) Held warrants. A warrant may be held by the department only in the following instances:

45.23(1) The recipient's whereabouts is unknown.

45.23(2) The recipient is not in the home due to an emergency and it is not known who will be serving as emergency payee.

441—45.24(239B) Underpayment. A corrective payment shall be made when the recipient receives a payment in an amount less than that for which the recipient was eligible due to an administrative or client error or the recipient reports the completion of the federal tax return requiring repayment to Internal Revenue Service of excess advance earned income credit payments received in the prior calendar year.

45.24(1) Attribution of underpayments.

a. An underpayment may be attributed to the local office as a result of one of the following circumstances:

(1) Misfiling or loss of forms or documents.

(2) Errors in typing or copying.

(3) Computer input errors.

(4) Mathematical errors.

(5) Failure to certify assistance in the correct amount when all essential information was available to the local office.

(6) Failure to make prompt revisions in grants following changes in policies requiring the changes as of a specific date.

b. An underpayment may be attributed to the client as a result of one of the following circumstances:

(1) Information reported in error, oral or written, regarding the client's income, resources, or other circumstances which may affect eligibility or the amount of assistance received.

(2) Failure to timely report changes in income, resources, or other circumstances which may affect eligibility or the amount of assistance received.

(3) Information reported in error regarding the existence of a sponsor or the income or resources of the sponsor and the sponsor's spouse, when a sponsor is financially responsible for an alien according to 441—subrules 41.25(6) and 41.27(1).

45.24(2) Conditions under which a retroactive corrective payment may be made.

a. Retroactive corrective payments shall be made for all underpayments.

b. Any retroactive corrective payment for which the recipient is eligible shall first be applied to any unpaid overpayment before the balance, if any, is paid to the recipient.

c. Retroactive corrective payments shall be made for underpayments discovered on and after October 1, 1981, regardless of when the underpayment occurred. Recipients and former applicants and recipients are responsible for supplying any information needed to determine the amount of an underpayment.

45.24(3) The amount of the corrective payment to the recipient for repayment to Internal Revenue Service of excess advance earned income credit payments shall be computed on the basis of the earnings considered in determining the family investment program grant for the prior year.

45.24(4) A retroactive corrective payment is:

a. Exempt from consideration as income.

b. Exempt from consideration as a resource in the month received and the following month.

441—45.25(239B) Deceased payees. A retroactive corrective payment shall be made for deceased payees only when the payment was approved by the local office prior to the recipient's death. Payment for a special need shall be made only when the payment is entered on the automated benefit calculation system prior to the effective date of cancellation.

441—45.26(239B) Limitation on payment. A payment shall be made to an eligible recipient only when the amount of the assistance is $10 or more.

441—45.27(239B) Rounding of need standard and payment amount. The need standard and monthly payment amount must be rounded down to the next whole dollar when the result of determining the standard of need or the payment amount is not a whole dollar.

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, and 239B.7.

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CHAPTER 46
OVERPAYMENT RECOVERY

[Prior to 7/1/83, Social Services[770] Ch 46]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—46.1 to **46.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, 441—46.1(239) to 46.8(239)]

441—46.21(239B) Definitions.

"Agency error" in overpayments means: (a) The same as circumstances described in 441—subrule 45.24(1) pertaining to underpayments, or (b) any error that is not a client or procedural error.

"Client" means a current or former applicant or recipient of the family investment program.

"Client error" means and may result from:

False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which may affect eligibility or the amount of assistance received;

Failure to timely report changes in income, resources, or other circumstances which may affect eligibility or the amount of assistance received;

Failure to timely report the receipt of and, if applicable, to refund assistance in excess of the amount shown on the most recent Notice of Decision, Form 470-0485(C) or 470-0486(M), or the receipt of a duplicate grant; or

Failure to refund to the child support recovery unit any nonexempt payment from the absent parent received after the date the decision on eligibility was made.

"Intentional program violation" is an action by a person for the purpose of establishing or maintaining the family's eligibility for FIP, or for increasing or preventing reduction in the grant amount by intentionally (1) making a false or misleading statement; (2) misrepresenting, concealing or withholding facts; or (3) acting with the intent to mislead, misrepresent, conceal or withhold facts, or provide false information.

"Overpayment" means any assistance payment received in an amount greater than the amount the eligible group is entitled to receive.

"Procedural error" means a technical error which does not in and of itself result in an overpayment. Procedural errors include:

Failure to secure a properly signed application at the time of initial application or reapplication.

Failure of the county office to conduct the face-to-face interviews described in 441—subrules 40.24(2) and 40.27(1).

Failure to request a Public Assistance Eligibility Report or a Review/Recertification Eligibility Document at the time of a monthly, semiannual, or annual review.

Failure of county office staff to cancel the family investment program when the client submits a Public Assistance Eligibility Report or a Review/Recertification Eligibility Document which is not complete as defined in 441—paragraph 40.27(4)*"b."* However, overpayments of grants as defined above based on incomplete reports are subject to recoupment.

"Recoup" means reimburse, return, or repay an overpayment.

"Recoupment" means the repayment of an overpayment, either by a payment from the client or an amount withheld from the assistance grant or both.

441—46.22(239B) Monetary standards.

46.22(1) *Amount subject to recoupment.* All family investment program overpayments shall be subject to recoupment.

46.22(2) *Grant issued.* When recoupment is made by withholding from the family investment program grant, the grant issued shall be for no less than $10.

441—46.23(239B) Notification and appeals. All clients shall be notified by the department of inspections and appeals, as described at 441—subrule 7.5(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The local office shall provide additional information regarding the computation of the overpayment upon the client's request. The client may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—subrule 7.5(6).

441—46.24(239B) Determination of overpayments. All overpayments due to agency or client error or due to assistance paid pending an appeal decision shall be recouped. A procedural error alone does not result in an overpayment.

46.24(1) *Agency error.* When an overpayment is due to an agency error, recoupment shall be made, including those instances when errors by the department prevent the requirements in 441—subrule 41.22(6) or 41.22(7) from being met or when the client receives a duplicate grant. An overpayment of any amount is subject to recoupment with one exception: When the client receives a grant that exceeds the amount on the most recent notice from the department, recoupment shall be made only when the amount received exceeds the amount on the notice by $10 or more. The client is required to timely report receipt of excess assistance under 441—subrule 40.27(4). An overpayment due to agency error shall be computed as if the information had been acted upon timely.

46.24(2) *Assistance paid pending appeal decision.* Recoupment of overpayments resulting from assistance paid pending a decision on an appeal hearing shall begin no later than the month after the month in which the final decision is issued.

46.24(3) *Client error.*

a. An overpayment due to client error shall be computed as if the information had been reported and acted upon timely.

b. Overpayments due to failure to refund payments received from the absent parent shall be the total nonexempt support payment made for members of the eligible group at the time the support payment was received. In addition, assistance payments made to meet the needs of the eligible group may also be subject to recoupment under provisions in 441—subrule 41.22(6).

46.24(4) *Failure to cooperate.* Failure to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months.

46.24(5) *Overpayment in special alien cases.* Rescinded IAB 10/4/00, effective 12/1/00.

46.24(6) *Real property exempted as a resource.* Rescinded IAB 6/30/99, effective 9/1/99.

441—46.25(239B) Source of recoupment. Recoupment shall be made from basic needs. The minimum recoupment amount shall be the amount prescribed in 46.25(3). Regardless of the source, the client may choose to make a lump sum payment, make periodic installment payments when an agreement to do this is made with the department of inspections and appeals, or have repayment withheld from the grant. The client shall sign Form 470-0495, Repayment Contract, when requested to do so by the department of inspections and appeals. When the client fails to make the agreed upon payment, the agency shall reduce the grant.

46.25(1) and **46.25(2)** Rescinded, effective February 8, 1984.

46.25(3) *Basic needs.*

a. Recoupment by withholding from basic needs for overpayments due to client error or a combination of client and agency errors shall be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

b. Recoupment by withholding from basic needs for overpayments due to the continuation of benefits pending a decision on an appeal as provided under rule 441—7.9(217) or a combination of continued benefits and agency or client errors shall be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

c. Recoupment by withholding from basic needs for overpayments due to agency error shall be 1 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

d. Rescinded IAB 6/30/99, effective 9/1/99.

46.25(4) *Recoupment in special alien cases.* Rescinded IAB 10/4/00, effective 12/1/00.

441—46.26 Rescinded, effective February 8, 1984.

441—46.27(239B) Procedures for recoupment.

46.27(1) Rescinded IAB 2/8/89, effective 4/1/89.

46.27(2) *Referral.* When the local office determines that an overpayment exists, the case shall be referred to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

46.27(3) Rescinded IAB 2/8/89, effective 4/1/89.

46.27(4) *Change of circumstances.* When financial circumstances change, the recoupment plan is subject to revision.

46.27(5) *Collection.* Recoupment for overpayments shall be made from the parent or nonparental relative who was the caretaker relative, as defined in 441—subrule 41.22(3), at the time the overpayment occurred. When both parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

46.27(6) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the case is canceled and the amount of the overpayment is less than $35. If the case is reopened within three years, recoupment is initiated again. Recoupment will be waived on nonfraud overpayments of less than $35 which have been held in suspense for three years.

441—46.28(239B) Intentional program violation. This rule applies to family investment program overpayments except for PROMISE JOBS expense allowance overpayments described at rule 441—93.151(239B).

46.28(1) *Referral.*

a. Administrative disqualification hearings. The following types of cases shall be referred for an administrative disqualification hearing: (1) cases with sufficient evidence to substantiate one or more acts of intentional program violation by the person, and (2) cases previously referred for prosecution that were declined by the legal authority or formally withdrawn by the state.

The department shall coordinate its FIP intentional program violation actions with any corresponding actions being taken under the food stamp program where the factual issues arise from the same or related circumstances.

Referrals shall be made by the county office for the aforementioned types of overpayments that are processed on or after November 1, 1996, even when the actual overpayment occurred before that date.

A referral shall be made regardless of the person's current eligibility status. More than one assistance unit member may be referred.

Referral shall be made by the county office to the appeals section of the department of human services. The referral shall be in writing and include a detailed statement of charges against the assistance unit member and evidence and shall identify each assistance program involved in the incident. The appeals division of the department of inspections and appeals shall notify the assistance unit member of the scheduled hearing on intentional program violation as described at 441—subrule 7.22(1).

Referral for an administrative disqualification hearing shall not be made on a person who has been referred to the department of inspections and appeals for a court hearing unless notified to do so by the department of inspections and appeals.

b. Court referrals. Court referrals shall be made to the investigations division of the department of inspections and appeals. The investigations division shall notify the department of the court's ruling. The department shall notify the person of the court's ruling and of any disqualification period. A referral shall be made regardless of the person's current eligibility status.

46.28(2) *Penalties.* A person found, either through an administrative disqualification hearing or by a court, to have committed an intentional program violation shall be ineligible to participate in the family investment program as follows: 6 months for the first violation; 12 months for the second violation; and permanently for the third violation. Only the persons found to have committed the intentional program violation shall be disqualified.

An intentional program violation imposed in another state shall be considered the same as if the person had committed an intentional program violation in Iowa in determining whether it is the person's first, second or third violation, provided the referral for intentional program violation by the other state occurred on or after November 1, 1996. In addition, the person shall be excluded from participation in the family investment program until the disqualification period determined by the other state has ended.

Income of the disqualified person shall be treated in accordance with 441—subparagraph 41.27(8)*"a"*(1) and subrule 41.27(11). When the disqualified person is a nonneedy nonparental relative, income is exempt.

Overpayments resulting from an intentional program violation shall be subject to rules 441—46.21(239B) to 46.25(239B) and 46.27(239B), except as otherwise specified.

46.28(3) *Disqualification period.*

a. The person found to have committed intentional program violation by an administrative disqualification hearing shall be disqualified the first month that action can be taken following the final decision as described at 441—subrule 7.22(5) regardless of the person's current eligibility status. Once the disqualification period begins, the disqualification shall continue uninterrupted until completed.

EXCEPTION: The period of disqualification may be subject to stay if the person files for judicial review and requests a stay order, and a stay order is issued by the court preventing the department from implementing the disqualification or interrupting a disqualification already in progress.

Only one disqualification period shall be imposed on the same person for the same time period regardless of the number of infractions that are stated in the referral for intentional program violation. Once a disqualification period is established, another disqualification period shall not be imposed for infractions that may have occurred before that period.

The person shall be notified in writing of the disqualification. For recipients, notice shall be subject to the limitations at 441—subrule 7.7(1).

The assistance unit shall agree to repay excess assistance in accordance with rule 441—46.25(239B).

b. A disqualification period ordered by the court shall be imposed as in paragraph *"a"* except as otherwise specified by the court order. When a court orders a disqualification period but does not specify a beginning date, the disqualification period shall begin within 45 days of the date disqualification was ordered.

441—46.29(239B) Fraudulent misrepresentation of residence. A person convicted in a state or federal court, or in an administrative hearing, of having made a fraudulent statement or representation of the person's place of residence in order to receive assistance simultaneously from two or more states shall be ineligible for assistance for ten years. For the purpose of this rule, the term "assistance" means assistance under Titles IV-A or XIX of the Social Security Act, or the Food Stamp Act of 1977, or benefits in two or more states under the Supplemental Security Income program under Title XVI. The ten-year period begins on the date the person is convicted. The prohibition does not apply to a convicted person who is pardoned by the President of the United States, beginning with the month after the pardon is given.

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, 239B.7, and 239B.14.

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CHAPTER 60
REFUGEE CASH ASSISTANCE

[Prior to 9/24/86 IAC Supp., see Refugee Service 715—Chapters 1 to 8]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

These rules define and structure the department's refugee cash assistance program. Eligibility criteria, application procedures, reasons for adverse action, payment procedures, and recoupment procedures for overpayments are outlined.

441—60.1(217) Alienage requirements.

60.1(1) *Immigration status.* Refugees with the following immigration status meet the alienage requirement:

a. A person from any country who has a "parole" status as a "refugee" or "asylee" under Section 212(d)(5) of the Immigration and Nationality Act.

b. A person admitted from any country as a "conditional entrant" under Section 203(a)(7) of the Immigration and Nationality Act.

c. A person admitted from any country as a "refugee" under Section 207 of the Immigration and Nationality Act.

d. A person from any country who has been granted "asylum" under Section 208 of the Immigration and Nationality Act.

e. An alien who was admitted to the United States under Section 584 of the Foreign Operations Appropriations Act as incorporated in the 1988 Continuing Resolution, Public Law 100-202.

f. A person from any country who previously held one of the statuses in subrule 60.1(1), paragraphs *"a"* through *"e,"* whose status has subsequently been adjusted to that of "permanent resident alien."

g. A person admitted as a spouse or minor child of an alien previously admitted to the United States as an asylee or as a Visa 92 beneficiary whose immigration documentation is inscribed with the words "Visa 92" and is also generally inscribed with the words "Section 208."

h. A person admitted as a spouse or minor child of an alien previously admitted to the United States as a refugee or a Visa 93 beneficiary whose immigration documentation is inscribed with the words "Visa 93" and is also generally inscribed with the words "Section 207."

60.1(2) *Nonrefugee child of refugee parents.* A nonrefugee child of refugee parents, when both parents in the home are refugees as defined in subrule 60.1(1), meets the alienage requirements. When only one parent is in the home and that parent is a refugee as defined in subrule 60.1(1), the child meets the alienage requirements.

60.1(3) *Immigration and Naturalization Service documents.* Each refugee shall provide Immigration and Naturalization Service documents in the form of either an I-94 card, an I-151 or I-551 card, or an I-181 card to support the immigration status defined in subrule 60.1(1). If the name of the resettlement agency which resettled the refugee is not on the document, the refugee shall provide the name of the resettlement agency.

441—60.2(217) Application procedures. Application policies are defined in rules 441—40.23(239B), 441—40.24(239B), and 441—40.25(239B).

441—60.3(217) Effective date of grant. The date of eligibility for a grant is defined in rule 441—40.26(239B).

441—60.4(217) Accepting other assistance.

60.4(1) *Family investment program.* A refugee applicant or recipient shall accept a family investment program (FIP) grant or a FIP-unemployed parent grant if eligible under 441—Chapters 40, 41, and 42.

60.4(2) *Supplemental security income (SSI).* Refugees who are 65 or older, blind, or disabled shall apply for and, if eligible, accept supplemental security income.

441—60.5(217) Eligibility factors.

60.5(1) *Age.*

a. An unmarried refugee is considered an adult at age 18, except as defined in 441—subrule 41.21(1), and is eligible to receive refugee cash assistance if otherwise eligible.

b. Married refugees with or without children, as defined in 441—subrule 41.21(1), are eligible regardless of age if other eligibility factors are met.

60.5(2) *Residency.* Residency requirements are defined in 441—subrule 41.23(1).

60.5(3) *Social security numbers.* Refugees are required to furnish a social security number as defined in 441—subrule 41.22(13).

60.5(4) *Determination of need.* Need shall be determined as defined in rule 441—41.28(239B) except as otherwise provided in this chapter.

60.5(5) *Income.* Income is defined in rules 441—40.21(239B) and 441—41.27(239B).

60.5(6) *Resources.* Resource requirements are defined in rule 441—41.26(239B).

441—60.6(217) Students in institutions of higher education. A refugee who is a full-time student in an institution of higher education (other than a correspondence school) is ineligible for assistance with two exceptions:

1. The refugee is in a program approved as part of an individual employability plan, as defined in subrule 60.9(3).
2. The refugee is in a program solely in English as a second language.

60.6(1) *Institution of higher education.* An institution of higher education is defined as an educational institution which provides an education program as specified below:

a. A public or private nonprofit institution of higher education is an educational institution which provides an educational program for which it awards an associate, baccalaureate, graduate, or professional degree; or at least a two-year program which is acceptable for full credit toward a baccalaureate degree; or at least a one-year training program which leads to a certificate or degree and prepares students for gainful employment in a recognized occupation.

b. A proprietary institution of higher education is an educational institution which provides at least a six-month program of training to prepare students for gainful employment in a recognized occupation.

c. A postsecondary vocational institution is a public or private nonprofit educational institution which provides at least a six-month program of training to prepare students for gainful employment in a recognized occupation.

60.6(2) *Full-time student.* A full-time student is a student who is carrying a full-time academic workload which equals or exceeds the following:

a. Twelve semester or 12 quarter hours per academic term in those institutions using standard semester, trimester, or quarter-hour systems.

b. Twenty-four semester hours or 36 quarter hours per academic year for institutions using credit hours to measure progress, but not using semester, trimester, or quarter systems, or the prorated equivalent for programs of less than one academic year.

c. Twenty-four clock hours per week for institutions using clock hours.

d. A series of courses or seminars which equals 12 semester hours or 12 quarter hours in a maximum of 18 weeks.

e. The work portion of a cooperative education program in which the amount of work performed is equivalent to the academic workload of a full-time student.

441—60.7(217) Time limit for eligibility. A refugee may receive assistance, if otherwise eligible, during the first eight months the refugee is in the United States, beginning the month the refugee enters the country. EXCEPTION: For asylees, the date of entry is the date asylum is granted. The eight-month period of eligibility begins the month asylum is granted. A nonrefugee child in the home with a refugee parent (or refugee parents, if both are in the home) is eligible for assistance until the parent(s) has been in the United States for eight months, or until the child reaches eight months of age, whichever occurs first.

60.7(1) *Resources.* The resources of refugees excluded because of the eight-month limit shall be considered in the same manner as though these refugees were included in the eligible group.

60.7(2) *Income.*

a. When the eligible refugee group has income, the income shall be diverted to meet the needs of the refugees ineligible because of the time limit who would otherwise have been included in the refugee assistance group as defined in subrule 60.5(4).

b. The income of the refugees ineligible because of the time limit who would otherwise have been included in the assistance group as defined in subrule 60.5(4), shall be used first to meet the needs of the ineligible group and then applied to the eligible group's needs.

c. The amount of need for the ineligible group is the difference between the needs of the group including the ineligible refugees and the needs of the group excluding the ineligible refugees. Any excess income shall be applied to the needs of the eligible group.

d. Any cash grant received by the applicant under the Department of State or the Department of Justice reception and placement programs shall be disregarded as income and as a resource.

441—60.8(217) Criteria for exemption from registration for employment services, registration, and refusal to register. Each refugee applying for or receiving cash assistance shall register for employment unless the department determines the refugee is exempt because of reasons listed in subrule 60.8(1). Inability to communicate in English does not exempt a refugee from registration for employment services, participation in employability service programs and acceptance of appropriate offers of employment.

60.8(1) *Exemptions.* The following refugees are exempt from registration:

a. A refugee who is under the age of 16; or who is aged 16 but under the age of 18 and attending elementary, secondary, or vocational or technical school full-time; or a refugee who is enrolled full-time in training approved by the local office as part of an approved employability plan; or a refugee 18 years of age who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching the age of 19.

(1) A refugee shall be considered as attending school full time when enrolled or accepted full time (as certified by the school or institute attended) in a school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) The refugee also shall be considered in regular attendance in months when the refugee is not attending because of an official school or training program, vacation, illness, convalescence, or family emergency. A refugee meets the definition of regular school attendance until the refugee has been officially dropped from the school rolls.

(3) When the refugee's education is temporarily interrupted pending adjustment of the education or training program, assistance shall be continued for a reasonable period of time to complete the adjustment.

b. A refugee aged 65 or older.

c. A refugee who is caring for another member of the household who has a physical or mental impairment which requires, as determined by a physician or licensed or certified psychologist and verified by the department, care in the home on a substantially continuous basis, and no other appropriate member of the household is available. The condition shall be established as specified in 441—paragraph 41.21(5)*"c."*

d. A woman who is pregnant if it has been medically verified that the child is expected to be born in the month in which registration would otherwise be required or within the next six months. Verification of the pregnancy and estimated date of birth shall be obtained in the same manner as specified in 441—paragraph 41.21(5)*"a."*

e. A parent or other caretaker relative of a child under the age of three who personally provides full-time care for the child with only very brief and infrequent absences from the child. Only one parent or other caretaker relative in a case may be exempt under this paragraph. "Brief and infrequent absence" means short-term absences which do not reoccur on a regular basis. Any involvement by the parent employed less than 129 hours per month or attending school less than full-time, as defined by the school, shall be considered brief and infrequent. Recreational activities and vacations by the parent or child which result in the parent being absent from the child shall be considered brief and infrequent.

f. A refugee who is working at least 30 hours a week in unsubsidized employment expected to last a minimum of 30 days. This exemption continues to apply if there is a temporary break in full-time employment expected to last no longer than ten workdays.

g. A refugee who is ill, when determined by the department on the basis of medical evidence or another sound basis that the illness or injury is serious enough to temporarily prevent entry into employment or training.

h. A refugee who is incapacitated, when determined by a physician or licensed or certified psychologist and verified by the department, that a physical or mental impairment, by itself or in conjunction with age, prevents the refugee from engaging in employment or training.

60.8(2) *Registration.* A refugee not exempt under subrule 60.8(1) shall be considered an employable refugee. An employable refugee shall register with the department of employment services and, within 30 days of receipt of aid, participate in the employment services provided by the bureau of refugee services. The department does permit, but does not require, the voluntary registration for employment services of any applicant or recipient of refugee cash assistance who is exempt under the provisions of this rule. If a voluntary registrant fails or refuses to participate in appropriate employability services, to carry out job search, or to accept an appropriate offer of employment, the bureau of refugee services may deregister the refugee for up to 90 days from the date of determination that failure or refusal has occurred, but the refugee's cash assistance may not be affected.

60.8(3) *Refusal to register.*

a. An employable applicant refugee who refuses or fails to cooperate in accepting a referral to the department of employment services or the bureau of refugee services, refuses or fails to appear at the department of employment services office for registration, or refuses or fails to mail or deliver the registration form to the bureau of refugee services, shall be denied assistance.

b. Assistance for an employable recipient refugee shall be terminated when the refugee refuses or fails to register with the department of employment services or the bureau of refugee services.

441—60.9(217) Work and training requirements.

60.9(1) *Standards applicable to both work and training assignments.* The following standards must be met before an employable refugee can be required to accept a work or training assignment. A job offered, if determined appropriate under subrules 60.9(1) and 60.9(2), is required to be accepted by the refugee without regard to whether the job would interrupt a program of services planned or in progress unless the refugee is currently participating in a program in progress of on-the-job training or vocational training approved as part of an individual's employability plan or the refugee is enrolled full-time in a professional recertification program approved as part of an individual's employability plan.

a. The job or training referral must be related to the physical and mental capability of the person to perform the task on a regular basis. Any claim of adverse effect on physical or mental health shall be based on adequate medical testimony from a physician or licensed or certified psychologist indicating that participation would impair the person's physical or mental health.

b. The total daily commuting time to and from home to the work or training site to which the person is referred shall not normally exceed two hours, not including the transporting of a child to and from a child care facility, unless a longer commuting distance and time is generally accepted in the community, in which case the round trip commuting time shall not exceed the generally accepted community standards.

c. The work or training site to which the person is referred must not be in violation of applicable federal, state, and local health and safety standards.

d. Referrals shall not be made which are discriminatory in terms of age, sex, race, creed, color, or national origin.

e. When child care is required, the child care must meet state licensing or registration requirements.

f. Available manpower statistics for a local area must indicate adequate employment potential for persons obtaining the given training. The employment must also meet the other appropriate work requirements.

g. The work or training assignment must be within the scope of the refugee's employability plan.

h. The quality of training must meet local employers' requirements so that the refugee will be in a competitive position within the local labor market. The training must also be likely to lead to employment which will meet the appropriate work criteria.

i. If a refugee is a professional in need of professional refresher training and other recertification services in order to qualify to practice the refugee's profession in the United States, the training may consist of full-time attendance in a college or professional training program, provided that the training is approved by the department as a part of the refugee's employability plan; it does not exceed one year's duration (including any time enrolled in the program in the United States prior to the refugee's application for assistance); it is specifically intended to assist the professional in becoming relicensed in the refugee's profession; and, if completed, it can realistically be expected to result in relicensing.

60.9(2) *Appropriate work requirements.* The local office, in making a determination of appropriate work, shall utilize the following criteria:

a. Appropriate work may be temporary, permanent, full-time, part-time, or seasonal work if it meets the other work standards defined in subrule 60.9(1).

b. The wage shall meet or exceed the federal or state minimum wage law, whichever is applicable, or if these laws are not applicable, the wage shall not be less favorable than the wage normally paid for similar work in that labor market but in no event shall it be less than three-fourths of the minimum wage rate.

c. The daily hours of work and the weekly hours of work shall not exceed those customary to the occupation.

d. No person shall be required to accept employment if:

(1) The position offered is vacant due to a strike, lockout, or other bona fide labor dispute.

(2) The person would be required to work for an employer contrary to the conditions of the person's existing membership in the union governing that occupation. However, employment not governed by the rules of a union in which the person has membership may be deemed appropriate.

60.9(3) *Development of an individual employability plan.* An individual employability plan shall be developed as a part of a family self-sufficiency plan where applicable for each recipient of refugee cash assistance in a filing unit who is not exempt under 441—subrule 60.8(1). The individual employability plan shall:

a. Be designed to lead to the earliest possible employment and not be structured in such a way as to discourage or delay employment or job seeking.

b. Contain a definite employment goal, attainable in the shortest time period consistent with the employability of the refugee in relation to job openings in the area.

60.9(4) *Job search requirements.* The department shall require job search for employable refugees where appropriate.

a. An employable recipient of refugee cash assistance shall carry out a job search program beginning at any time required by the bureau of refugee services. The bureau of refugee services shall require the job search program to begin no later than six months after the refugee entered the United States or at the time the refugee is determined eligible for refugee cash assistance, if the refugee has completed at least six months in the United States at the time of the determination.

b. The job search program shall continue for at least eight consecutive weeks and shall meet requirements that the bureau of refugee services determines appropriate, including the amount of time to be devoted to employer contacts per week or the number of employer contacts required per week.

c. The department shall determine and carry out the procedures it considers necessary to ensure that requirements for participation in job search are met.

60.9(5) *Failure or refusal to accept employability services or employment.*

a. Unless the refugee is exempt as described at rule 441—60.8(217), the department shall terminate assistance when an employable recipient of refugee cash assistance has failed or refused to comply with any of the following requirements without good cause. The refugee shall:

(1) Register for employment with the department of employment services and, within 30 days of receipt of cash assistance, participate in employment services provided by the bureau.

(2) Apply for or accept an offer of employment meeting the standards above.

(3) Carry out job search.

(4) Go to a job interview arranged by the department or its designee.

(5) Participate in an employability service program which is determined to be available and appropriate for that refugee.

(6) Not voluntarily quit a job.

(7) Participate in a social service or targeted assistance program which the department determines to be available and appropriate for that refugee.

b. In cases of proposed action to terminate, discontinue, suspend, or reduce assistance, the department shall give timely and adequate notice, following the same procedures as those used in the family investment program. The written notice shall include:

(1) An explanation of the reason for the action and the consequences of failure or refusal.

(2) Notice of the refugee's right to file an appeal with the department. The department shall determine whether a hearing shall be granted.

c. For the first refusal or failure the refugee shall be sanctioned for three payment months. Subsequent refusals or failures shall result in a six-payment month sanction for each refusal or failure.

d. If the sanctioned individual is the only member of the filing unit, the assistance shall be terminated. If the filing unit includes other members, the department shall not take into account the sanctioned individual's needs in determining the filing unit's need for assistance. If the sanctioned individual is a caretaker relative, assistance provided to the other persons in the grant shall be made in the form of protective payments as defined in rule 441—43.22(239B).

e. A conciliation period prior to the imposition of sanctions must be provided for in accordance with the following time limitations. The conciliation effort shall begin as soon as possible, but no later than 10 days following the date of failure or refusal to participate, and may continue for a period not to exceed 30 days. Either the department or the recipient may terminate this period sooner when either believes that the dispute cannot be resolved by conciliation.

441—60.10(217) Uncategorized factors of eligibility.

60.10(1) *Duplication of assistance.* A refugee whose needs are included in a refugee cash assistance grant shall not concurrently receive a grant under any other public assistance program administered by the department. Neither shall a recipient concurrently receive a grant from a public assistance program in another state.

60.10(2) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive refugee cash assistance when the other party, obligated to provide the support, is able to fulfill that part of the contract.

60.10(3) *Participation in a strike.*

a. The spouse and children shall be ineligible for assistance for any month in which the other spouse or parent is participating in a strike on the last day of the month.

b. Any person shall be ineligible for assistance for any month in which the person is participating in a strike on the last day of that month.

c. Definitions of a strike and participating in a strike are defined in 441—subrule 41.25(5), paragraph *"c."*

441—60.11(217) Temporary absence from home. Temporary absence from home is defined in 441—subrule 41.23(3).

441—60.12(217) Application. The application shall be processed as defined in 441—40.22(239B).

441—60.13(217) Continuing eligibility. Continuing eligibility shall be determined as defined in rule 441—40.27(239B) except that refugee cash assistance shall be substituted for the family investment program whenever it appears.

441—60.14(217) Alternate payees. Alternate payees are defined in 441—Chapter 43 except that refugee cash assistance shall be substituted for the family investment program whenever it appears.

EXCEPTION: 441—subrule 43.22(1), paragraph *"c,"* shall not apply to refugee cash assistance applicants or recipients.

441—60.15(217) Payment. Payment shall be issued as defined in 441—Chapter 45 except that refugee cash assistance shall be substituted for the family investment program whenever it appears.

441—60.16(217) Overpayment recovery. Recovery of overpayments and intentional program violation shall be determined as defined in 441—Chapter 46, Division II, except that refugee cash assistance shall be substituted for the family investment program whenever it appears.

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75.1(21) *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(22) *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form PA-1107, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) *Pregnant women, infants and children (Mothers and Children (MAC)).* Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 185 percent of the federal poverty level for pregnant women when establishing initial eligibility under these provisions and for infants (under one year of age) when establishing initial and ongoing eligibility. Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. Family income is the income remaining after disregards and deductions have been applied in accordance with the provisions of rule 441—75.57(249A).

In determining eligibility for pregnant women and infants, after the aforementioned disregards and deductions have been applied, an additional disregard equal to 15 percent of the applicable federal poverty level shall be applied to the family's income.

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with paragraph 75.57(9)*"c."*

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed $10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

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

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

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

h. When determining eligibility under this coverage group, the deprivation requirements specified at subrule 75.54(3), living with a specified relative as specified at subrule 75.54(2), and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person's monthly income does not exceed the following percentage of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved:

(1) 85 percent effective January 1, 1989.

(2) 90 percent effective January 1, 1990.

(3) 100 percent effective January 1, 1991, and thereafter.

(4) Rescinded IAB 1/9/91, effective 1/1/91.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either prior to the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. The pregnant woman shall complete Form 470-2927, Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Income Calculation Worksheet for Presumptive Medicaid Eligibility Determinations, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.
2. Rural health clinic services (if contained in the state plan).
3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

(4) Rehabilitative treatment services pursuant to 441—Chapter 185.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy recipients with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118, Medically Needy Recertification/State Supplementary and Medicaid Review, as part of the review process when requested to do so by the county office.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related recipient who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the recipient's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Medically Needy Recertification/State Supplementary and Medicaid Review, Form 470-3118, shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on recertifications. A face-to-face interview is not required for recertifications if the last face-to-face interview was less than 12 months ago and there has not been a break in assistance. When the length of time between face-to-face interviews would exceed 12 months, a face-to-face interview shall be required.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medically Needy Recertification/State Supplementary and Medicaid Review, Form 470-3118, to be recertified. This form shall be treated as an application. For cases on the X-PERT system, if an interview is required as specified at subparagraph 75.1(35)*"j"*(2), the applicant may complete Form 470-3112 or 470-3122 (Spanish). When the applicant completes Form 470-3112 or Form 470-3122 (Spanish), the Summary of Facts, Form 470-3114, shall be completed and attached to the Summary Signature Page, Form 470-3113 or Form 470-3123 (Spanish), which has been signed and returned to the local or area office.

If an interview is not required as specified at subparagraph 75.1(35)*"j"*(2), when the Application for Assistance, Part 1, Form 470-3112 or 470-3122 (Spanish), is completed, the applicant shall be requested to complete Form 470-3118.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, a Disability Report, Form 470-2465, must be obtained from the applicant or recipient or the applicant's or recipient's authorized representative. A signed Authorization for Source to Release Information to the Department of Human Services, Form 470-2467, shall be completed for each medical source listed on the disability report.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility.

75.1(36) *Expanded specified low-income Medicare beneficiaries.* Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

a. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

c. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The person is not otherwise eligible for Medicaid.

e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) *Home health specified low-income Medicare beneficiaries.*

a. Medicaid benefits to cover the cost of the home health portion of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

(1) The person's monthly income is at least 135 percent of the federal poverty level but is less than 175 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(2) The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

(3) The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

(4) The person is not otherwise eligible for Medicaid.

b. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

c. Payment of the home health portion of Medicare Part B premium shall be made retroactively on an annual basis in April of each year for the prior calendar year.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

441—75.25(249A) Definitions.

"Aged" shall mean a person 65 years of age or older.

"Applicant" shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Blind" shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Break in assistance" for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

"Central office" shall mean the state administrative office of the department of human services.

"Certification period" for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

"Client" shall mean an applicant for or a recipient of Medicaid.

"CMAP-related medically needy" shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

"Community spouse" shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Conditionally eligible recipient" shall mean a medically needy person who has completed the application process and has been assigned a certification period and spenddown amount but who has not spent down for the certification period.

"Coverage group" shall mean a group of persons who meet certain common eligibility requirements.

"Department" shall mean the Iowa department of human services.

"Disabled" shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

"Eligible recipient" under the provisions of the medically needy program shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced excess income through spenddown to the MNIL during the certification period.

"FMAP-related medically needy" shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

"Group health insurance" shall mean any plan of, or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Health insurance" shall mean protection which provides payment of benefits for covered sickness or injury.

"Incurred medical expenses" for medically needy shall mean (1) medical bills paid by a recipient, responsible relative or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the recipient or responsible relative remains obligated.

"Institutionalized person" shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

"Institutionalized spouse" shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Local office" shall mean the county office of the department of human services or the mental health institute or hospital school.

"Medically needy income level (MNIL)" shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

"Necessary medical and remedial services" for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

"Noncovered Medicaid services" for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

"Nursing facility services" shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

"Obligated medical expense" for medically needy shall mean a medical expense for which the recipient or responsible relative continues to be legally liable.

"Ongoing eligibility" for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

"Pay and chase" shall mean that the state pays the total amount allowed under the agency's payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

"Payee" refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

"Recertification" in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Recipient" shall mean a person who is receiving assistance including receiving assistance for another person.

"Responsible relative" for medically needy shall mean a spouse, parent, or stepparent living in the household of the eligible recipient.

"Retroactive certification period" for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" shall mean the three calendar months immediately preceding the month in which an application is filed.

"Spenddown" shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

"SSI-related" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

"SSI-related medically needy" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

"Supply" shall mean the requested information is received by the department by the specified due date.

"Transfer of assets" shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

"Unborn child" shall include an unborn child during the entire term of pregnancy.

"X-PERT" means an automated knowledge-based computer system that determines eligibility for Medicaid and other assistance programs.

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) *Class settlement payments.* Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) *Other settlement payments.* Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

441—75.28 to **75.49** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions.

"Applicant" shall mean a person who is requesting assistance on the person's own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Application period" means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

"Assistance unit" includes any person whose income is considered when determining eligibility.

"Bona fide offer" means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

"Budget month" means the calendar month from which the county office uses income or circumstances of the eligible group to calculate eligibility.

"Central office" shall mean the state administrative office of the department of human services.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Change in work expenses" means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

"Client" shall mean an applicant or recipient of Medicaid.

"Department" shall mean the Iowa department of human services.

"Income in-kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which eligibility is granted.

"Medical institution," when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

"Nonrecurring lump sum unearned income" means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers' compensation.

"Parent" means the natural or adoptive parent.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Recipient" means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Schedule of needs" means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

"Stepparent" means a person who is the legal spouse of the child's natural or adoptive parent by ceremonial or common-law marriage.

"Unborn child" shall include an unborn child during the entire term of the pregnancy.

"Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Eligibility for the family medical assistance program (FMAP) and FMAP-related programs shall be reinstated without a new application when all necessary information is provided at least three working days before the effective date of cancellation and eligibility can be reestablished, except as provided in the transitional Medicaid program in accordance with subparagraph 75.1(31)*"j"*(2).

Assistance may be reinstated without a new application when all necessary information is provided after the third working day but before the effective date of cancellation and eligibility can be reestablished before the effective date of cancellation.

When all eligibility factors are met, assistance shall be reinstated when a completed Review/Recertification Eligibility Document, Form 470-2881, is received by the county office within ten days of the date a cancellation notice is sent to the recipient because the form was incomplete or not returned.

441—75.52(249A) Continuing eligibility.

75.52(1) *Reviews.* Eligibility factors shall be reviewed at least annually for the family medical assistance program and family medical assistance-related programs. A face-to-face interview shall be conducted at least annually at the time of a review for adults using information contained in and verification supplied with Form 470-2881, Review/Recertification Eligibility Document.

75.52(2) *Additional reviews.* A redetermination of specific eligibility factors shall be made when:

a. The recipient reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the recipient's circumstances comes to the attention of a staff member.

75.52(3) *Forms.* Information for the annual face-to-face determination interview shall be submitted on Form 470-2881, Review/Recertification Eligibility Document (RRED). When the client has completed Form 470-0462, Public Assistance Application, for another purpose, this form may be used as the review document for the semiannual or annual review.

75.52(4) *Recipient responsibilities.* For the purposes of this subrule, recipients shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The recipient shall complete Form 470-2881, Review/Recertification Eligibility Document (RRED), when requested by the county office in accordance with these rules. The form shall be supplied as needed to the recipient by the department. The department shall pay the cost of postage to return the form. When the form is issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the county office by the fifth calendar day of the report month. When the form is not issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the county office by the seventh day after the date it is mailed by the department. The county office shall supply the recipient with a RRED upon request. Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, signed, dated no earlier than the first day of the budget month and accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

c. The recipient shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.
(2) Resources.
(3) Members of the household.
(4) School attendance.
(5) Becoming incapacitated or recovery from incapacity.
(6) Change of mailing or living address.
(7) Payment of child support.
(8) Receipt of a social security number.
(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)*"b."*
(10) Health insurance premiums or coverage.

d. All recipients shall timely report any change in the following circumstances at any time:

(1) Members of the household.
(2) Change of mailing or living address.
(3) Sources of income.
(4) Health insurance premiums or coverage.

e. Recipients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

(1) A person enters or leaves the household.
(2) The mailing or living address changes.
(3) A source of income changes.
(4) A health insurance premium or coverage change is effective.
(5) Of any change in income.
(6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4)*"c"* through *"e,"* any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4)*"c"* through *"e."*

75.52(5) *Effective date.* After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual's needs shall be removed effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) *Definition of resident.* A resident of Iowa is one:

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

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

75.53(2) *Retention of residence.* Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) *Temporary absence from the home.* The needs of an individual who is temporarily out of the home are included in the eligible group unless the person is in a jail or penal institution, including a work release center, in accordance with the provisions of rule 441—75.12(249A) or is excluded from the eligible group in accordance with the provisions of rule 441—75.59(249A). A temporary absence exists in the following circumstances.

a. An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the individual's needs being removed from the eligible group.

b. When an individual is out of the home to secure education or training, as defined for children in paragraph 75.54(1)*"b"* and for adults in 441—subrule 93.114(1), first sentence, as long as the specified relative retains supervision of the child.

c. An individual is out of the home for reasons other than reasons in paragraphs *"a"* and *"b"* and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

441—75.54(249A) Eligibility factors specific to child.

75.54(1) *Age.* Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month's needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3). The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2). Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)*"e,"* 75.57(6)*"u,"* and 75.57(7)*"o."* Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided. The county office shall return all verification to the applicant or recipient.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income, from investment and nonrecurring lump sum payments, shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the applicant or recipient sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payment reported by child support recovery during the budget month shall be used to determine prospective and retrospective eligibility for the corresponding eligibility month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8)*"c."*

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

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

b. The value of the coupon allotment in the food stamp program.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Rescinded IAB 2/11/98, effective 2/1/98.

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

u. The first $50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

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

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

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

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

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

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

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

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for a job-related expense.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family for providing foster care when the family is operating a licensed foster home.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

f. Earned income credit.

g. Supplementation from county funds, providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective payment.

j. The training allowance issued by the division of vocational rehabilitation, department of education.

k. Payments from the PROMISE JOBS program.

l. The training allowance issued by the department for the blind.

m. Payments from passengers in a car pool.

n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

o. Rescinded IAB 10/4/00, effective 10/1/00.

p. Rescinded IAB 10/4/00, effective 10/1/00.

q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.

r. Rescinded IAB 10/4/00, effective 10/1/00.

s. Compensation in lieu of wages received by a child under the Job Training Partnership Act of 1982.

t. Any amount for training expenses included in a payment issued under the Job Training Partnership Act of 1982.

u. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)*"b"*(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

EXCEPTION: Income that terminated in one of the two initial months occurring at time of an initial application that was not used prospectively shall be considered retrospectively as required by subparagraph 75.57(9)*"b"*(1). This subrule shall not apply to nonrecurring lump sum income defined at subparagraph 75.57(9)*"c"*(2).

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group, but is living with the parent in the home of the eligible child(ren), shall be given the same consideration and treatment as that of a natural parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2)*"b"*(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8)*"b"*(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 50 percent work incentive deduction from monthly earnings. The deduction shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8)*"b"*(1) through (5) have been subtracted from the earnings. However, the 50 percent work incentive deduction is not allowed when determining initial eligibility as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt nonrecurring lump sum received by a stepparent shall be considered as income in the budget month and counted in computing eligibility. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependent but ineligible children living in the home, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any dependent but ineligible children of the parent shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)*"b"*(1) through (7). Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)*"b"*(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) *Budgeting process.*

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application for which a face-to-face interview is completed pursuant to 441—subrule 76.2(1), all earned and unearned income received by the eligible group during the 30 days prior to the interview shall be used to project future income unless the applicant provides verification that those 30 days are not indicative of future income. Upon application for which a face-to-face interview is not completed pursuant to subrule 441—76.2(1), all earned and unearned income received by the eligible group during the 30 days prior to the application date shall be used to project future income unless the applicant provides verification that those 30 days are not indicative of future income. If the applicant provides verification that the 30-day period specified above is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income. Allowable work expenses shall be deducted from earned income, except when determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 50 percent earned income disregard as specified at paragraph 75.57(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of basic needs (Test 3) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of basic needs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(3) When the countable net income is less than the schedule of living costs (Test 2) for the eligible group, the 50 percent earned income disregard at paragraph 75.57(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the earned income disregards at paragraph 75.57(2)*"c"* and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply.

When the countable net income is less than the payment standard for the eligible group, the application shall be approved.

(4) The family circumstances shall be considered, based upon the anticipated circumstances during each month.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Work expense for care, as defined at paragraph 75.57(2)*"b,"* shall be the average allowable care expense expected to be billed or otherwise expected to become due during a month. The 20 percent earned income deduction for each wage earner, as defined at paragraph 75.57(2)*"a,"* and the 50 percent work incentive deduction, as defined at paragraph 75.57(2)*"c,"* shall be allowed.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)*"d"* and *"e"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)*"c"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. Lump sum income.

(1) Recurring lump sum income. Recurring lump sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months. Income received by an individual employed under a contract shall be prorated over the period of the contract. Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months, except periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)*"i."* When the lump sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

(2) Nonrecurring lump sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with this rule. Nonrecurring lump sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers' compensation. Nonrecurring lump sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt. When countable income exclusive of any family investment program grant but including countable lump sum income exceeds the needs of the eligible group under their current coverage group, the countable lump sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump sum income and any other countable income received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period of time is referred to as the period of proration.

Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter. The period of proration shall begin with the month following a ten-day notice of adverse action when the receipt of the lump sum was timely reported. The period of proration shall begin with the month following the receipt of the lump sum when the receipt of the lump sum was not timely reported. The period of proration shall be shortened when the schedule of living costs as defined at subrule 75.58(2) increases. The period of proration shall be shortened by the amount which is no longer available to the eligible group due to loss, theft, or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group.

The period of proration shall also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

When countable income, including the lump sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt. For purposes of applying the lump sum provision, the eligible group is defined as all eligible persons and any other individual whose lump sum income is counted in determining the period of proration. During the period of proration, individuals not in the eligible group when the lump sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income, excluding the lump sum income already considered, of the parent or other legally responsible person in the home shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)*"b,"* shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual's needs, income, and resources shall be included. The needs, income, and resources of an individual determined to be ineligible to remain a member of the eligible group shall be removed prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the county office shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 75.14(2) or who is required to be included in the eligible group according to paragraph 75.58(1)*"a"* and has failed to cooperate. This restriction applies to paragraph 75.57(4)*"a"* and subrule 75.57(8).

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules):

(1) The dependent child and any sibling of the child, of whole or half blood or adoptive, if the sibling is living in the same home as the dependent child and if the sibling meets the eligibility requirements of age and school attendance specified at subrule 75.54(1). When eligibility is being established under subrule 75.1(14), subparagraph 75.1(35)*"a"*(2), or 75.1(35)*"a"*(5), the child must be deprived as specified at subrule 75.54(3).

(2) Any natural or adoptive parent of such child, if the parent is living in the same home as the dependent child.

b. The following persons may be included:

(1) The needy relative who assumes the role of parent.

(2) The needy relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) The incapacitated stepparent, upon request, when the stepparent is the legal spouse of the natural or adoptive parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the natural or adoptive parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

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76.2(2) *Choice of coverage groups.* An applicant who meets the eligibility requirements of more than one coverage group shall be given the choice of coverage group under which eligibility shall be determined.

76.2(3) *Conditional benefits granted previous to October 1, 1993.* When the client is receiving Medicaid under the conditional benefit policy of the SSI program pursuant to subrule 75.13(2), the client shall be required to describe the efforts that are made to sell the property on Form 470-2908, Description of Efforts to Sell Property, as requested by the department. The department shall request that the form be completed no more often than specified. For personal property being sold Form 470-2908 shall be completed no more often than every 30 days during the conditional benefit period. For real property being sold Form 470-2908 shall be completed beginning 35 days after conditional benefits are granted and no more often than every 60 days thereafter for nine months. If eligibility continues and the real property is not sold, the form shall be completed no more often than every 90 days.

76.2(4) *Monthly reporting.* Rescinded IAB 10/4/00, effective 10/1/00.

76.2(5) *Reporting of changes.* The applicant shall report no later than at the time of the face-to-face interview any change as defined at 441—paragraph 75.52(4)*"c"* which occurs after the application was signed. Changes that occur after the face-to-face interview shall be reported by the applicant in accordance with paragraph 75.52(4)*"c."*

441—76.3(249A) Time limit for decision. Applications shall be investigated by the county department of human services. A determination of approval, conditional eligibility, or denial shall be made as soon as possible, but no later than 30 days following the date of filing the application unless one or more of the following conditions exist.

76.3(1) The application is being processed for eligibility under the medically needy coverage group as defined in 441—subrule 75.1(35). Applicants for medically needy shall receive a written notice of approval, conditional eligibility, or denial as soon as possible, but no later than 45 days from the date the application was filed.

76.3(2) An application on the client's behalf for supplemental security income benefits is pending.

76.3(3) The application is pending due to completion of the requirement in 441—subrule 75.1(7).

76.3(4) The application is pending due to nonreceipt of information which is beyond the control of the client or department.

76.3(5) The application is pending due to the disability determination process performed through the department.

76.3(6) Unusual circumstances exist which prevent a decision from being made within the specified time limit. Unusual circumstances include those situations where the county office and the applicant have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit has expired or because of emergency situations such as fire, flood, or other conditions beyond the administrative control of the department.

441—76.4(249A) Notification of decision. The applicant or recipient will be notified in writing of the decision of the local office regarding the applicant's or recipient's eligibility for Medicaid. If the applicant or recipient has been determined to be ineligible an explanation of the reason will be provided.

76.4(1) The recipient shall be given a timely and adequate written notice as provided in 441—subrule 7.7(1) when any decision or action is being taken by the local office which adversely affects Medicaid eligibility or the amount of benefits.

76.4(2) Timely notice may be dispensed with but adequate notice shall be sent, no later than the effective date of action, when one or more of the conditions in 441—subrule 7.7(2) are met.

76.4(3) A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility, conditional eligibility or ineligibility.

441—76.5(249A) Effective date.

76.5(1) *Three-month retroactive eligibility.*

a. Medical assistance benefits shall be available for all or any of the three months preceding the month in which the application is filed to persons who meet both of the following conditions:

(1) Have medical bills for covered services which were received during the three-month retroactive period.

(2) Would have been eligible for medical assistance benefits in the month services were received, if application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance benefits shall be made available when an application has been made on behalf of a deceased person if the conditions in paragraph *"a"* are met.

d. Persons receiving only supplemental security income benefits who wish to make application for Medicaid benefits for three months preceding the month of application shall complete Form MA-2124-0, Supplementary Information—Medicaid Application—Retroactive Medicaid Eligibility.

e. Rescinded IAB 10/8/97, effective 12/1/97.

76.5(2) *First day of month.*

a. For persons approved for the family medical assistance-related programs, medical assistance benefits shall be effective on the first day of a month when eligibility was established anytime during the month.

b. For persons approved for supplemental security income, programs related to supplemental security income, or state supplementary assistance, medical assistance benefits shall be effective on the first day of a month when the individual was resource eligible as of the first moment of the first day of the month and met all other eligibility criteria at any time during the month.

c. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first of the month in which the request was made.

d. When a request is made to add a person to the eligible group who previously was excluded, in accordance with the provisions of rule 441—75.59(249A), assistance shall be effective no earlier than the first of the month following the month in which the request was made.

76.5(3) *Care prior to approval.* No payment shall be made for medical care received prior to the effective date of approval.

441—76.6(249A) Certification for services. The department of human services shall issue a Medical Assistance Eligibility Card (Fee-for-Service), Form 470-1911, to persons determined to be eligible for the benefits provided under the Medicaid program unless one of the following situations exists:

76.6(1) *Lock-in.* The eligible person is receiving Medicaid under the recipient lock-in provisions defined at rule 441—76.9(249A). These persons shall be issued a Medical Assistance Eligibility Card (Lock-in), Form 470-3348, by the department.

76.6(2) *Managed care.* The eligible person is receiving Medicaid through any form of managed health care as defined at 441—Chapter 88. Those persons shall be issued Form 470-2213, Medical Assistance Eligibility Card (Managed Care).

76.6(3) *Aliens.* The eligible person is an alien who is receiving Medicaid only for emergency services as provided in rule 441—75.11(249A). These persons shall be issued a Medical Assistance Eligibility Card (Limited Benefits), Form 470-2188, by the department.

76.6(4) *Qualified Medicare beneficiary.* The eligible person is receiving Medicaid under the Qualified Medicare Beneficiary program. These persons shall be issued a Medical Assistance Eligibility Card (Limited Benefits), Form 470-2188, by the department.

These persons shall be eligible only for payment of Medicare premiums, deductibles, and coinsurance, as provided in 441—subrule 75.1(29).

76.6(5) *Pregnant woman.* The eligible person is a pregnant woman determined presumptively eligible in accordance with 441—subrule 75.1(30). These persons shall be issued a Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, by the department.

441—76.7(249A) Reinvestigation. Reinvestigation shall be made as often as circumstances indicate but in no instance shall the period of time between reinvestigations exceed 12 months.

The recipient shall supply, insofar as the recipient is able, additional information needed to establish eligibility within five working days from the date a written request is issued. The recipient shall give written permission for the release of information when the recipient is unable to furnish information needed to establish eligibility. Failure to supply the information or refusal to authorize the county office to secure information from other sources shall serve as a basis for cancellation of Medicaid.

Eligibility criteria for persons whose eligibility for Medicaid is related to the family medical assistance program shall be reviewed according to policies found in rule 441—75.52(249A).

Persons whose eligibility for Medicaid is related to supplemental security income shall complete Form 470-3118, Medically Needy Recertification/State Supplementary and Medicaid Review, as part of the reinvestigation process when requested to do so by the county office.

The review for foster children or children in subsidized adoption shall be completed on Form 470-2914, Foster Care and Subsidized Adoption Medicaid Review, according to the time schedule of the family medical assistance program or supplemental security income program for disabled children, as applicable.

441—76.8(249A) Investigation by quality control or the food stamp investigation section of the department of inspections and appeals. The recipient or applicant shall cooperate with the department when the recipient's case is selected by quality control or the food stamp investigation section of the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules 481—Chapter 72.) Failure to do so shall serve as a basis for cancellation of assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

441—76.9(249A) Recipient lock-in. In order to promote high quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, recipients that utilize medical assistance services or items at a frequency or in an amount which is considered to be overuse of services as defined in subrule 76.9(7) may be restricted (locked-in) to receive services from a designated provider(s).

76.9(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

76.9(2) Provider selection. The recipient may select the provider(s) from which services will be received. The selection shall be made by using Form MA-4068, Designation of Primary Providers. The designated providers will be identified on the Medical Assistance Eligibility Card (Lock-in), Form 470-3348. Only prescriptions written or approved by the designated primary physician(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 76.9(3).

76.9(3) Payment will be made to provider(s) other than the designated (lock-in) provider(s) in the following instances:

a. Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

b. The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

c. The designated provider refers the recipient to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

76.9(4) When the recipient fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the recipient.

76.9(5) Recipients may change designated provider(s) when a change is warranted, such as when the recipient has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the recipient shall make the determination when the recipient has demonstrated that a change is warranted. Recipients may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

76.9(6) When lock-in is imposed on a recipient, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

76.9(7) Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

a. Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception reporting technique to identify the recipients most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

b. In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph *"a,"* referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects utilization of Medicaid recipient outpatient visits to physicians, family and pediatric nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid recipients who are enrolled in the MediPASS program or a health maintenance organization, or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term "physician" does not include a psychiatrist.

c. An investigation process of Medicaid recipients determined in paragraphs *"a"* or *"b"* to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also unusual based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or consultants for the department. These medical judgments shall be made by the health professionals on the basis of the body of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.

441—76.10(249A) Applicant and recipient responsibilities.

76.10(1) An applicant or recipient eligible for Medicaid because of income and resource policies related to the supplemental security income (SSI) program, except for actual recipients of SSI, shall timely report any changes in the following circumstances to the department:

a. Income from all sources.
b. Resources.
c. Membership of the household.
d. Recovery from disability.
e. Mailing or living address.
f. Health insurance premiums or coverage.
g. Medicare premiums or coverage.
h. Receipt of social security number.
i. Gross income of the community spouse or dependent children, parents or siblings of the institutionalized or community spouse living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)
j. Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.
k. Residence in a medical institution for other than respite care for more than 15 days for home and community-based recipients.

76.10(2) An applicant or recipient eligible for Medicaid because of the family medical assistance program (FMAP) income and resource policies shall report changes in accordance with 441—paragraphs 75.52(4)*"c"* through *"e."* After assistance has been approved, changes occurring during the month are effective the first day of the next calendar month, provided the notification requirements at rule 441—76.4(249A) can be met.

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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.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Respite providers certified under the HCBS MR waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).

(8) Residential care facilities for persons with mental retardation (RCF/PMR) licensed by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

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

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

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

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

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

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

(1) At least 18 years of age.

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

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

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

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

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

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

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

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

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

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(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.

77.30(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Licensed child care centers.

(2) Registered group child care homes.

(3) Registered family child care homes.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

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.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the HCBS MR waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

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

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

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

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

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

e. Providers certified under the HCBS MR waiver.

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

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

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

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

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

e. Hospitals enrolled as Medicaid providers.

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

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

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

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

a. Area agencies on aging as designated in 321—4.4(231). 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.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the HCBS MR waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

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

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

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

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

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

c. Hospitals enrolled as Medicaid providers.

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

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

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

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

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

77.34(7) *Adult day care providers.* Adult day care providers shall 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). Interim medical monitoring and treatment providers shall meet the conditions set forth in subrule 77.37(22).

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.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.
b. (Outcome 3) Consumers live in positive environments.
c. (Outcome 4) Consumers work in positive environments.
d. (Outcome 5) Consumers exercise their rights and responsibilities.
e. (Outcome 6) Consumers have privacy.
f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
g. (Outcome 8) Consumers decide which personal information is shared and with whom.
h. (Outcome 9) Consumers make informed choices about where they work.
i. (Outcome 10) Consumers make informed choices on how they spend their free time.
j. (Outcome 11) Consumers make informed choices about where and with whom they live.
k. (Outcome 12) Consumers choose their daily routine.
l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
m. (Outcome 14) Consumers have a social network and varied relationships.
n. (Outcome 15) Consumers develop and accomplish personal goals.
o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
p. (Outcome 17) Consumers maintain good health.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. Living units designed to serve more than three supported community living recipients shall be approved only as follows:

(1) Living units designed to serve four recipients shall be approved subject to all of the following conditions:

1. Only existing residential facility structures owned or operated by the provider as of November 4, 1994, shall be used.

2. The provider shall provide justification of the need for the service to be provided in a four-person living unit instead of a living unit for three persons or less.

3. The requirements of Iowa Code paragraph 135C.6(8)*"b"* shall be met.

(2) The department shall approve a total of 20 living units for five persons or fewer which are licensed as residential care facilities for persons with mental retardation. The residential care facility shall surrender the facility license and continue to operate under the medical assistance home- and community-based services waiver for persons with mental retardation. Applications from providers for conversion shall be submitted to the Division of Mental Health and Developmental Disabilities, Hoover State Office Building, Fifth Floor, Des Moines, Iowa 50319-0114.

1. There shall be four conversions in each of the department's five service regions. The department may reallocate any unused conversion authorization to another region.

2. Recommendations for conversions will be made to the department by an advisory committee set up for each of the five regions. For each region the members shall include all of the central point of coordination administrators, with an advisory representative from the department. Each region shall submit its recommendation for the allocation of its four facilities currently licensed as residential care facilities for persons with mental retardation that will convert to home- and community-based waiver services for persons with mental retardation.

3. Approval of providers shall be made by the department's mental health and developmental disabilities division. Approval of providers shall be based on the advisory committee's recommendation, the geographical distribution of providers, and the counties' written assurance that they will request sufficient slots for the consumers to be served and agree to provide necessary funding.

(3) Subject to federal approval, a residential program which serves not more than eight individuals and is licensed as an intermediate care facility for persons with mental retardation may surrender the facility license and continue to operate under the home- and community-based services waiver for persons with mental retardation if the department has approved the timelines submitted by the residential program pursuant to subparagraph 77.37(14)*"d"*(1).

77.37(15) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation (RCF/PMR) licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day health services accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

(7) Home care agencies that meet the home care standards and requirements set forth in department of public health rules 641—80.5(135) through 641—80.7(135).

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) *Supported employment providers.*

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

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

(2) Procedures for payment schedules and pay scale.

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

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

(5) Department of labor requirements.

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

77.37(17) *Home and vehicle modification providers.* A home and vehicle modification provider shall be an approved HCBS MR supported community living service provider and shall meet the following standards:

a. The provider shall obtain a binding contract with community business(es) to perform the work at the reimbursement provided by the department without additional charge. The contract shall include, at a minimum, the company or individual's work to be performed, 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 78.41(4).

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.

d. The business, or the business's parent company or corporation, shall be in compliance with all legislation relating to prohibition of discriminatory practices.

77.37(18) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) *Nursing providers.* The following nursing providers may provide HCBS MR nursing services:

a. Providers which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

b. Individuals who meet the standards and requirements set forth in nursing board rules 655—Chapter 3, work under the direct orders of the HCBS MR consumer's physician, and have an HCBS agreement with the department.

77.37(20) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

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

(1) At least 18 years of age.

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

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

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

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

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

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

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

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

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

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

77.37(22) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Licensed child care centers.

(2) Registered group child care homes.

(3) Registered family child care homes.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

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

441—77.38(249A) Rehabilitative treatment service providers. Rehabilitative treatment service providers are eligible to participate in the Medicaid program if they are certified to be providers pursuant to rules 441—185.9(234) to 441—185.11(234).

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

441—77.39(249A) HCBS brain injury waiver service providers. Adult day care, behavioral programming, case management, consumer-directed attendant care, family counseling and training, home and vehicle modification, interim medical monitoring and treatment, personal emergency response, prevocational service, respite, specialized medical equipment, supported community living, supported employment, and transportation providers shall be eligible to participate as approved brain injury waiver service providers in the Medicaid program based on the applicable subrules pertaining to the individual service and provided that they and each of their staff involved in direct consumer service have training regarding or experience with consumers who have a brain injury. In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) *Departmental reviews.* Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) *Supported community living providers.*

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve not more than four supported community living consumers meeting criteria listed below:

(1) The department shall approve the four-person or less HCBS brain injury waiver living units on a statewide basis. Approval shall be according to the provider's ability to meet the criteria in rule 441—77.39(249A). New four-person structures not owned or operated as of November 9, 1994, shall not be approved. Use of existing residential facility structures owned or operated by the provider as of November 9, 1994, must be justified by the need for the service to be provided in a four-person living unit instead of a three- or less person living unit. The geographic location of the program must be such so as to avoid an overconcentration of programs in an area.

(2) Providers of service may seek approval to provide supported community living services to not more than four HCBS brain injury waiver consumers per living unit according to subrule 77.39(8) if all consumers residing in the living unit receive on-site staff supervision during the entire time period consumers are present in the living unit and if each consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

77.39(14) *Respite service providers.* Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

(1) Respite providers certified under the HCBS mental retardation waiver.

(2) Adult day health service providers accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

(3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(4) Camps certified by the American Camping Association.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation (RCF/PMR) licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) *Supported employment providers.*

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

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

(2) Procedures for payment schedules and pay scale.

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

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

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

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

77.39(16) *Home and vehicle modification providers.* 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.

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

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

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Supported community living providers certified under rules 441—77.39(13).

77.39(24) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

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

(1) At least 18 years of age.

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

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

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

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

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

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

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

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

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

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25 and has submitted a detailed cost account. The cost account shall provide a methodology for determining the cost of consumer-directed attendant care.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Licensed child care centers.

(2) Registered group child care homes.

(3) Registered family child care homes.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

441—77.40(249A) Lead inspection agency providers. Lead inspection agency providers are eligible to participate in the Medicaid program if they are certified pursuant to 641—subrule 70.5(4), department of public health.

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

441—77.41(249A) HCBS physical disability waiver service providers. Consumer-directed attendant care, home and vehicle modification, personal emergency response system, specialized medical equipment, and transportation service providers shall be eligible to participate as approved physical disability waiver service providers in the Medicaid program based on the applicable subrules pertaining to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's division of medical services quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

c. The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties to be served by the provider.

77.41(2) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

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

(1) At least 18 years of age.

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

(3) Not the spouse or guardian of the consumer.

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

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

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

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

e. Community action agencies as designated in Iowa Code section 216A.103.

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

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

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(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.

77.41(3) *Home and vehicle modification providers.* A home and vehicle modification provider shall be either:

a. An approved HCBS brain injury or mental retardation supported community living service provider that meets all the following standards:

(1) The provider shall obtain a binding contract with a community business 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.

(2) The business shall provide physical or structural modifications to homes or vehicles according to service descriptions listed in 441—subrule 78.46(2).

(3) 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.

b. A community business that performs the work and meets all the following standards:

(1) The community business shall enter into binding contracts with consumers 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.

(2) The business shall provide physical or structural modifications to homes or vehicles according to service descriptions listed in 441—subrule 78.46(2).

(3) 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.

77.41(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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Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the recipient's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of recipient in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.
b. Type of service to be rendered and the treatment modalities being used.
c. Frequency of the services.
d. Assistance devices to be used.
e. Date home health services were initiated.
f. Progress of recipient in response to treatment.
g. Medical supplies to be furnished.
h. Recipient's medical condition as reflected by the following information, if applicable:
(1) Dates of prior hospitalization.
(2) Dates of prior surgery.
(3) Date last seen by a physician.
(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
(5) Prognosis.
(6) Functional limitations.
(7) Vital signs reading.
(8) Date of last episode of instability.
(9) Date of last episode of acute recurrence of illness or symptoms.
(10) Medications.
i. Discipline of the person providing the service.
j. Certification period (no more than 62 days).
k. Estimated date of discharge from the hospital or home health agency services, if applicable.
l. Physician's signature and date. The date of the signature shall be within the certification period.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the recipient or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the recipient, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The recipient requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the recipient to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the recipient in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the recipient's institutionalization when the primary need of the recipient for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the recipient, e.g., lives alone or with family.

78.9(8) *Medical social services.*

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

(1) Are reasonable and necessary to the treatment of a recipient's illness or injury.

(2) Contribute meaningfully to the treatment of the recipient's condition.

(3) Are under the direction of a physician.

(4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.

(5) Address social problems that are impeding the recipient's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the recipient and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the recipients are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

Treatment plans for maternity patients and children shall identify the potential risk factors, the medical factor or symptom which verifies the child is at risk, the reason the recipient is unable to obtain care outside of the home, and the medically related task of the home health agency. If the home health agency is assisting the family to cope with socioeconomic and medical problems, the plan of care shall indicate the involvement of the department's county office and document that the department and the home health agency have agreed that services are in the best interest of the child and are needed to supplement the intervention of the department social worker.

The plan of treatment shall document along with the high-risk factors, the diagnosis, specific services and goals, and the medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

a. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

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 services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

e. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite, or group respite as defined in rule 441—83.1(249A).

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

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.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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

78.37(5) *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 are 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, hypodermoclysis, 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 condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

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

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are those set forth in subrule 78.41(4), paragraphs *"a"* to *"d."*

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the Case Management Program for the Frail Elderly (CMPFE) interdisciplinary team. A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip or rate established by area agency on aging. When paying the rate established by an area agency on aging, the monthly payment shall not exceed $200 per month for wheelchair or other handicapped transportation, or $100 per month for nonhandicapped transportation.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is one hour.

78.37(15) *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 provided by an individual or an agency, other than an assisted living program, is 1 hour, or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, 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 services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is otherwise reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

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

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

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.

f. Provider budgets shall reflect all staff-to-consumer ratios. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

g. The maximum number of units available per consumer is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the consumer's individual comprehensive plan.

i. Services shall not be simultaneously reimbursed with other residential services, HCBS MR respite, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

78.41(2) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the consumer's waiver year.

e. The service shall be identified in the consumer's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS MR waiver supported community living services, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

h. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.41(3) *Personal emergency response system.* The personal emergency response system is an electronic component that transmits a coded signal via digital equipment to a central monitoring station. The electronic device allows a person to access assistance in the event of an emergency when alone.

a. The necessary components of the system are:

(1) An in-home medical communications transceiver.

(2) A remote, portable activator.

(3) A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

(4) Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

b. The service shall be identified in the consumer's individual comprehensive plan.

c. A unit is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.41(4) *Vehicle and home modifications.* Covered vehicle and home 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 Medicaid state plan 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, fire safety alarm equipment specific for hearing and visually disabled, voice-activated, light-activated, 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 provided 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 binding contract between the supported community living service 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.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the consumer which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS MR supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the consumer's individual comprehensive plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

(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.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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.

d. Living units shall be located throughout the community at scattered sites. Settings larger than four units require the majority of living units to be occupied by individuals who are not disabled.

e. Provider budgets shall reflect all staff-to-consumer ratios. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 19 or more hours during a 24-hour calendar day and the consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

f. The maximum numbers of units available per consumer are as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the consumer's individual comprehensive plan.

h. Services shall not be simultaneously reimbursed with other residential services, HCBS brain injury waiver respite, transportation or personal assistance services, Medicaid nursing, or Medicaid home health aide services.

78.43(3) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the provider is a camp.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.43(4) *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 78.43(4)*"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 (carpools, 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 work site 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 Public Law 94-142.

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

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.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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. Rescinded IAB 9/6/00, effective 11/1/00.

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.

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement 2000 Iowa Acts, Senate File 2435, section 9.

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Provider category	Basis of reimbursement	Upper limit
Clinics	Fee schedule	Maximum physician reimbursement rate
Community mental health centers	Fee schedule	Reimbursement rate for center in effect 6/30/00 plus 17.33%
Dentists	Fee schedule	75% of usual and customary rate
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/00 plus 0.7%
Family or pediatric nurse practitioner	Fee schedule	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Family planning clinics	Fee schedule	Fees in effect 6/30/00 plus 0.7%
Federally qualified health centers (FQHC)	Retrospective cost-related	1. Reasonable cost as determined by Medicare cost reimbursement principles 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
HCBS AIDS/HIV waiver service providers, including:		
1. Counseling		
Individual:	Fee schedule	$10.07 per unit
Group:	Fee schedule	$40.26 per hour
2. Home health aide	Retrospective cost-related	Maximum Medicare rate
3. Homemaker	Fee schedule	$18.49 per hour
4. Nursing care	Agency's financial and statistical cost report and Medicare percentage rate per visit	Cannot exceed $74.77 per visit

Provider category	Basis of reimbursement	Upper limit
5. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care

Provider category	Basis of reimbursement	Upper limit
Foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
Child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
6. Home-delivered meal providers	Fee schedule	$7.19 per meal. Maximum of 14 meals per week
7. Adult day care	Fee schedule	Veterans administration contract rate or $20.54 per half day, $41.09 per full day, or $61.63 per extended day if no veterans administration contract.
8. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
HCBS brain injury waiver service providers, including:		
1. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$32.64 per hour, $73.61 per day
2. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care
Residential care facilities for persons with mental retardation	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
Foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
Child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
3. Personal emergency response system	Fee schedule	Initial one-time fee of $46.22. Ongoing monthly fee of $35.95.
4. Case management	Fee schedule	$575.49 per month
5. Supported employment:		
a. Instructional activities to obtain a job	Fee schedule	$34.70 per day
b. Initial instructional activities on the job	Retrospectively limited prospective rates. See 79.1(15)	$15.77 per hour
c. Enclave	Retrospectively limited prospective rates. See 79.1(15)	$5.78 per hour
d. Follow-along	Fee schedule. See 79.1(15)	$262.91 per month
6. Transportation	Fee schedule	State per mile rate
7. Adult day care	Fee schedule	$20.54 per half day, $41.09 per full day, or $61.63 per extended day
8. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 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	$10.07 per 15 minutes
12. Family counseling and training	Fee schedule	$40.26 per hour
13. Prevocational services	Fee schedule	$34.94 per day

Provider category	Basis of reimbursement	Upper limit
14. Interim medical monitoring and treatment:		
Home health agency:		
Provided by home health aide	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate
Provided by nurse	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate
Provided by a registered group child care home, registered family child care home, or licensed child care center	Contractual rate. See 441—subrule 170.4(7)	$12.24 per hour
HCBS elderly waiver service providers, including:		
1. Adult day care	Fee schedule	Veterans administration contract rate or $20.54 per half day, $41.09 per full day, or $61.63 per extended day if no veterans administration contract.
2. Emergency response system	Fee schedule	Initial one-time fee $46.22. Ongoing monthly fee $35.95.
3. Home health aides	Retrospective cost-related	Maximum Medicare rate
4. Homemakers	Fee schedule	Maximum of $18.49 per hour
5. Nursing care	Fee schedule as determined by Medicare	$74.77 per visit
6. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
7. Chore providers	Fee schedule	$7.19 per half hour
8. Home-delivered meal providers	Fee schedule	$7.19 per meal. Maximum of 14 meals per week.

Provider category	Basis of reimbursement	Upper limit
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
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	$7.70 per quarter hour
13. Assistive devices	Fee schedule	$102.71 per unit
14. Senior companion	Fee schedule	$6.16 per hour
15. Consumer-directed attendant care:		
Agency provider other than an assisted living program	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Assisted living provider	Fee agreed upon by consumer and provider	$1,052 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $34.60 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
HCBS ill and handicapped waiver service providers, including:		
1. Homemakers	Fee schedule	Maximum of $18.49 per hour
2. Home health aides	Retrospective cost-related	Maximum Medicare rate
3. Adult day care	Fee schedule	Veterans administration contract rate or $20.54 per half day, $41.09 per full day, or $61.63 per extended day if no veterans administration contract.
4. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care
Residential care facilities for persons with mental retardation	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
Foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services

Provider category	Basis of reimbursement	Upper limit
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
Child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
5. Nursing care	Agency's financial and statistical cost report and Medicare percentage rate per visit	Cannot exceed $74.77 per visit
6. Counseling		
Individual:	Fee schedule	$10.07 per unit
Group:	Fee schedule	$40.26 per hour
7. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
8. Interim medical monitoring and treatment:		
Home health agency:		
Provided by home health aide	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate
Provided by nurse	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate
Provided by a registered group child care home, registered family child care home, or licensed child care center	Contractual rate. See 441—subrule 170.4(7)	$12.24 per hour

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)	$32.64 per hour, not to exceed a total per month of $73.61 times the number of days in the month. $73.61 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 $73.61 per day.
2. Respite care providers, including:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$31.50 per hour not to exceed $294 per day
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$16.80 per hour not to exceed $294 per day

Provider category	Basis of reimbursement	Upper limit
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Facility care:		
Hospital or nursing facility providing skilled care	$12.24 per hour	$12.24 per hour not to exceed daily per diem for skilled nursing facility level of care
Nursing facility	$12.24 per hour	$12.24 per hour not to exceed daily per diem for nursing facility level of care
Intermediate care facility for the mentally retarded	$12.24 per hour	$12.24 per hour not to exceed daily per diem for ICF/MR level of care
Residential care facilities for persons with mental retardation	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
Foster group care	$12.24 per hour	$12.24 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.24 per hour not to exceed $294 per day
Adult day care	$12.24 per hour	$12.24 per hour not to exceed rate for regular adult day care services
Child care facilities	$12.24 per hour	$12.24 per hour not to exceed contractual daily per diem
3. Supported employment:		
a. Instructional activities to obtain a job	Fee schedule	$34.70 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)	$15.77 per hour. Maximum of 40 units per week
c. Enclave	Retrospectively limited prospective rates. See 79.1(15)	$5.78 per hour. Maximum of 40 units per week
d. Follow-along	Fee schedule. See 79.1(15)	$262.91 per month. Maximum of 12 units per fiscal year or $8.62 per day for a partial month.

Provider category	Basis of reimbursement	Upper limit
4. Nursing	Fee schedule as determined by Medicare	Maximum Medicare rate converted to an hourly rate
5. Home health aides	Retrospective cost-related	Maximum Medicare rate converted to an hourly rate
6. Personal emergency response system	Fee schedule	Initial one-time fee of $38.42 Ongoing monthly fee of $26.19
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	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
9. Interim medical monitoring and treatment:		
Home health agency:		
Provided by home health aide	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed the maximum daily per diem for ICF/MR level of care
Provided by nurse	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate converted to an hourly rate not to exceed the maximum daily per diem for ICF/MR level of care
Provided by a registered group child care home, registered family child care home, or licensed child care center	Contractual rate. See 441—subrule 170.4(7)	$12.24 per hour not to exceed the maximum daily per diem for ICF/MR level of care
HCBS physical disability waiver service providers, including:		
1. Consumer-directed attendant care:		
Agency provider	Fee agreed upon by consumer and provider	$18.49 per hour $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour $71.90 per day
2. Home and vehicle modification providers	Fee schedule	$500 per month, not to exceed $6000 per year

Provider category	Basis of reimbursement	Upper limit
3. Personal emergency response system	Fee schedule	Initial one-time fee of $46.22. Ongoing monthly fee of $35.95.
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.
Hearing aid dealers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/00 plus 0.7%
Home health agencies (Encounter services-intermittent services)	Retrospective cost-related	Maximum Medicare rate
(Private duty nursing or personal care and VFC vaccine administration for persons aged 20 and under)	Interim fee schedule with retrospective cost settling based on Medicare methodology	Retrospective cost settling according to Medicare methodology
Hospices	Fee schedule as determined by Medicare	Medicare cap (See 79.1(14)*"d"*)

Provider category	Basis of reimbursement	Upper limit
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/00 increased by 3%
Hospitals (Outpatient)	Prospective reimbursement for providers listed at 441—paragraphs 78.31(1)*"a"* to *"f."* See 79.1(16)	Ambulatory patient group rate (plus an evaluation rate) and assessment payment rate in effect on 6/30/00 increased by 3%
	Fee schedule for providers listed at 441—paragraphs 78.31(1)*"g"* to *"n."* See 79.1(16)	Rates in effect on 6/30/00 increased by 3%
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. See 79.1(6)
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from 12/31/99 cost reports
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/00 plus 0.7%
Nurse-midwives	Fee schedule	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A)	Seventieth percentile of facility costs as calculated from all 6/30/00 cost reports
2. Skilled nursing care provided in: Hospital-based facilities	Prospective reimbursement. See 79.1(9)	Facility base rate per diems used on 6/30/99 inflated by 2% subject to a maximum allowable payment rate of $346.20 per day for hospital-based skilled facilities

Provider category	Basis of reimbursement	Upper limit
Freestanding facilities	Prospective reimbursement. See 79.1(9)	Facility base rate per diems used on 6/30/99 inflated by 2% subject to a maximum allowable payment rate of $163.41 per day for freestanding skilled facilities
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Reimbursement rate for provider in effect 6/30/00 plus 0.7%
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Orthopedic shoe dealers	Fee schedule	Reimbursement rate for provider in effect 6/30/00 plus 0.7%
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18)
Physical therapists	Fee schedule	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology, excluding anesthesia services. Anesthesia services will be reimbursed at the Iowa Medicaid fee schedule rate in effect 6/30/00 plus 0.7%.
Podiatrists	Fee schedule	Rate in effect on 1/1/00 under the fee schedule established for Iowa under the federal Medicare program, incorporating the resource-based relative value scale (RBRVS) methodology
Prescribed drugs	See 79.1(8)	$4.13 or $6.42 dispensing fee (See 79.1(8)*"a"* and *"e"*)

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *Reimbursement for HCBS MR and BI supported community living and supported employment and HCBS AIDS/HIV, BI, elderly, ill and handicapped, and MR respite when basis of reimbursement is retrospectively limited prospective rate.* This includes home health agencies providing group respite; nonfacility providers of specialized, basic individual, and group respite; camps; and home care agencies providing specialized, basic individual, and group respite.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form SS-1703-0, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the department, division of medical services, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the division of medical services by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved individual comprehensive plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer travel and transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The annual adjustment shall be equal to the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the division of medical services. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

u. PRO review. For outpatient claims with dates of service ending July 1, 1994, and after, the PRO will review a yearly random sample of at least 500 hospital outpatient service cases performed for Medicaid recipients and identified on fiscal agent claims data from all Iowa and bordering state hospitals. The PRO will perform review activities on all APG categories for concerns relating to admission review, quality review, and APG validation. Questionable cases will be referred to a physician reviewer for concerns relating to medical necessity and quality of care. The PRO will also conduct a retrospective review of hospital claims assessing observation bed status lasting more than 24 hours. The review will consist of an evaluation for the appropriateness of the admission and continued stay in the observation bed status. Questionable cases will be referred to a physician reviewer for determination of the medical necessity.

When a review identifies a potential adverse determination by the PRO, an initial letter informing the provider about the adverse action will be sent and the provider will be given an opportunity to submit additional information about the case. This information will be taken into account prior to the final review determination. If the final review decision is upheld, a final letter will be sent to all parties. A reconsideration process will be available to all parties when there are payment consequences associated with the decision. The fiscal agent will be notified of all decisions resulting in payment consequences and appropriate adjustments will be made to claims.

Hospitals with cases under review must submit all requested supporting data from the medical record to the PRO within 60 days of receipt of the request or payment for those services may be recouped and forfeited. The hospital may request a review by submitting documentation to the PRO within 365 calendar days of the claim adjudication date. If a request is not filed by the hospital within that time, the hospital loses the right to appeal or contest that payment.

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The amount in the fund and distributions from the fund shall be calculated as follows:

(1) Allocation for direct medical education. To determine the total amount of funding that will be allocated to the graduate medical education and disproportionate share fund, the department shall:

1. Sum all direct medical education add-on payments for outpatient services using paid claims to qualifying providers on or after July 1, 1998, and through June 30, 1999.

2. Sum all direct medical education add-on payments for outpatient services, using claims reimbursed to qualifying providers, when those claims have been used as a basis for the calculation of capitation rates and reimbursement with any health maintenance organization (HMO) or other prepaid health plan with which the department has entered into a contract effective on or after July 1, 1997.

For each prepaid health plan, divide the total dollar reimbursement from claims by the number of member months applicable to the rate-setting methodology for the per member per month (PMPM) allocation to calculate the amount of reimbursement to be allocated to the fund that represents capitation rate reimbursement allocation for direct medical education. The direct medical education PMPM allocation shall then be multiplied by the total number of members enrolled in the plan for state fiscal year 1997, allocating that amount of money to the fund.

3. Trend the total allocation for direct medical education (which includes money for both the fee for service population and the capitated risk-based population, calculated under numbers "1" and "2" above) forward using annually appropriated legislative update factors and determine the total amount of money that shall be allocated to the graduate medical education and disproportionate share fund for direct medical education Medicaid reimbursement. No adjustments shall be made to this fund beyond appropriated amounts.

(2) Distribution of direct medical education. Distribution of the fund for direct medical education shall be on a monthly basis beginning October 1, 1997, and shall be calculated by taking the previous fiscal year's percentage allocation of direct medical education reimbursement (based upon paid outpatient claims to qualifying hospitals) and multiplying that percentage by the amount in the fund for direct medical education.

If a hospital fails to qualify for the provision of medical education under Medicare regulations, the amount of money that would have been allocated that hospital shall be removed from the total fund.

w. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Money shall be added to or subtracted from the graduate medical education and disproportionate share fund, when the average monthly Medicaid population deviates from the previous year's averages by greater than 5 percent. The average annual population (expressed in a monthly total) shall be determined on June 30 for both the previous and current years by adding the total enrolled population for all respective months from both years' B-1 MARS report and dividing each year's totals by 12. If the average monthly number of enrolled persons for the current year is found to vary more than 5 percent from the previous year, a PMPM amount shall be calculated for each component (using the average number of eligibles for the previous year calculated above) and an annualized PMPM adjustment shall be made for each eligible person that is beyond the 5 percent variance.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

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

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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.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"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.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"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 assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility or an intermediate care facility for the mentally retarded which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"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.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

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.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for 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. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

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

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)"*b*"(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

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.

c. Eligibility for persons covered under subrule 83.2(1)*"c"*(3) shall exist on the date the income and resource eligibility and level of care determinations and case plan are completed, but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care. Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from ill and handicapped waiver services and reviewed for eligibility for other Medicaid coverage groups. The recipient will be notified of that decision through Form SS-1104-0, Notice of Decision. If the client returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization 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—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of ill and handicapped waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker for ill and handicapped waiver services, Medicaid shall make no payments to ill and handicapped waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the ill and handicapped waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current case plan meeting the requirements listed in rule 441—83.7(249A).

441—83.6(249A) Allowable services. Services allowable under the ill and handicapped waiver are homemaker services, home health services, adult day care services, respite care services, nursing services, counseling services, consumer-directed attendant care services, and interim medical monitoring and treatment services as set forth in rule 441—78.34(249A).

441—83.7(249A) Case plan. A case plan shall be prepared for ill and handicapped waiver clients in accordance with rule 441—130.7(234) except that case plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition. In addition, the case plan shall include the frequency of the ill and handicapped waiver services and the types of providers who will deliver the services.

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the ill and handicapped waiver service for the person exceed the aggregate monthly costs established in 83.2(2)*"b."*

c. The client receives care in a hospital, nursing facility, or intermediate care facility for the mentally retarded for 30 days in any one stay for purposes other than respite care.

d. The client receives ill and handicapped waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(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—83.12 to **83.20** Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"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.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"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.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

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	$1,052

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."

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"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.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"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.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"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.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

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.

441—83.50(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 section 249A.4.

441—83.51 to **83.59** Reserved.

DIVISION IV—HCBS MR WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with mental retardation aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

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

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with mental retardation aged 17 or under.

"Client participation" means the posteligibility amount of the consumer's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Individual comprehensive plan (ICP)" (also known as individual program plan) means a written consumer-centered outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It involves more than one agency.

"Individual treatment plan (ITP)" (also known as an individual service plan, individual education plan, and individual habilitation plan) means a written goal-oriented plan of services developed for a consumer by the consumer and the provider agency.

"Intermediate care facility for the mentally retarded (ICF/MR)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons who are mentally retarded and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each individual function at the greatest ability and is an approved Medicaid vendor.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Mental retardation" means a diagnosis of mental retardation under this division which shall be made only when the onset of the person's condition was prior to the age of 18 years and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

"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.

"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.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"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.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

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 • 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.

i. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

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.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) *"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS 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.

441—83.62(249A) Application.

83.62(1) *Application for HCBS MR waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS MR waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/MR care. The case manager or worker shall have the consumer or legal representative complete and sign Part E of Form SS-1645, Home and Community Based Service Report, indicating the consumer's choice of care.

d. HCBS MR waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS MR waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification 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 needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual ICP staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization 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—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of eligibility for HCBS MR waiver services 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—83.61(249A).

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS MR waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modifications, supported employment, consumer-directed attendant care services, and interim medical monitoring and treatment services as set forth in rule 441—78.41(249A).

441—83.67(249A) Individual comprehensive plan or service plan. An individual comprehensive plan (ICP) or service plan shall be prepared and utilized for each HCBS MR waiver consumer. The ICP or service plan shall be developed by the interdisciplinary team which includes the consumer and, if appropriate, the legal representative, consumer's family, case manager or service worker, service 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. The service plan or ICP shall incorporate the concept of managed care. 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:

83.67(1) A listing of all services received by a consumer at the time of waiver program enrollment.

83.67(2) For supported community living consumers the plan shall include identification of:

a. The consumers' living environment at the time of waiver enrollment.

b. The number of hours per day of on-site staff supervision needed by the consumer.

c. The number of other waiver consumers who will live with the consumer in the living unit.

83.67(3) Rescinded IAB 1/4/95, effective 3/1/95.

83.67(4) An identification and justification of any restriction of a consumer's rights including, but not limited to:

a. Maintenance of personal funds.

b. Self-administration of medications.

83.67(5) The name of the service provider responsible for providing the service.

83.67(6) The service funding source.

83.67(7) The amount of the service to be received by the consumer.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

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

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.
Malignant neoplasms of brain, frontal lobe.
Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.

Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Individual comprehensive plan (ICP)" (also known as individual program plan) means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It involves more than one provider.

"Individual treatment plan (ITP)" (also known as an individual service plan, individual education plan, and individual habilitation plan) means a written, goal-oriented plan of services developed for a consumer by the consumer and the provider.

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

"Iowa Foundation for Medical Care" is the entity designated by the federal government to be the peer review organization for the state of Iowa.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for the mentally retarded, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"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.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"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.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

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.

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

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. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total monthly cost of brain injury waiver services shall not exceed $2,650 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Access to HCBS BI waiver services for adult persons meeting the ICF/MR level of care shall be limited to persons who are residing in an ICF/MR and who have resided there for at least 30 days immediately preceding waiver application. In addition, waiver slots for these persons shall be identified in the county management plan submitted to the department pursuant to 441—Chapter 25. Each county shall inform the department regarding the number of payment slots desired by April 1 and October 1 of each year. A county may choose to establish no payment slots under the HCBS BI waiver.

a. The payment slots shall be on a county basis for adults with legal settlement in a county and 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 shall be put on a waiting list shall be sent to the person by the department.

83.82(4) *Securing a payment slot.*

a. The county department office shall contact the division of medical services for state cases and children or the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS BI waiver program which require the ICF/MR level of care.

(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.

(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.

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 BI 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 applications 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 shall have financial responsibility for the state share of the costs of services for these consumers as stated in rule 83.90(249A). The county shall include these ICF/MR level of care brain-injured consumers in their annual county management plan which is approved by the state.

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application. The discharge planner shall provide to the Iowa Foundation for Medical Care (IFMC) review coordinator all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IFMC review coordinator shall inform the discharge planner on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. A consumer shall be given the choice between waiver services and institutional care. The consumer or legal representative shall complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the consumer's choice of caregiver. This shall be arranged by the medical facility discharge planner.

d. The medical facility discharge planner shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's ICP and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver 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.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

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, consumer-directed attendant care services, and interim medical monitoring and treatment 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 Agreement, 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).

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CHAPTER 93
PROMISE JOBS PROGRAM
[Prior to 7/1/89, see 441—Chapters 55, 59 and 90]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—93.1 to **93.100** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, 441—93.1(249C) to 93.52(249C)]

PREAMBLE

This chapter implements the PROMISE JOBS* program which is designed to increase the availability of employment and training opportunities to family investment program (FIP) recipients. It implements the family investment agreement (FIA) as directed in legislation passed by the Seventy-fifth General Assembly and signed by the governor on May 4, 1993, and approved under federal waiver August 13, 1993. The program also implements the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Title I—Block Grants for Temporary Assistance for Needy Families (TANF).

The program assigns responsibility for the provision of services to the Iowa department of workforce development (IWD) and IWD's subcontractors as appropriate. In addition, the bureau of refugee services (BRS) of the department of human services is assigned the responsibility of providing program services, to the extent compatible with resources available, to all refugees.

PROMISE JOBS services, which are also FIA options, include orientation, assessment, job-seeking skills training, group and individual job search, classroom training programs ranging from basic education to postsecondary education opportunities, entrepreneurial training, PROMISE JOBS on-the-job training, work experience, unpaid community service, parenting skills training, life skills training, monitored employment, the FIP-unemployed parent work program, referral for family planning counseling, volunteer mentoring, FaDSS, and other family development services. In addition, participants have access to all services offered by IWD and its subcontractor provider agencies. Persons in other work and training programs outside of PROMISE JOBS or not approvable by PROMISE JOBS can use those as FIA options.

441—93.101(239B) Program area. The department of human services shall administer an employment and training program known as PROMISE JOBS. The PROMISE JOBS program shall include the family investment agreement (FIA). The program shall be available statewide. If the department determines that sufficient funds are not available to offer on-location services in each county, it shall prioritize the availability of services in those counties having the largest FIP populations.

441—93.102(249C) Agency responsibility for provision of each service. Rescinded IAB 12/8/93, effective 1/1/94.

*See definition in 441—40.21(239B)

441—93.103(239B) Contracts with provider agencies for provision of services. The department of human services shall contract with the departments of workforce development and economic development to provide PROMISE JOBS and FIA services to FIP recipients. Services shall include orientation, assessment, job-seeking skills training, group and individual job search, job placement and job development, high school completion, adult basic education (ABE), general educational development (GED), and English as second language (ESL), vocational classroom training, postsecondary education, PROMISE JOBS on-the-job training (OJT), work experience, unpaid community service, parenting skills training, monitored employment, FaDSS, other family development services, referral for family planning counseling, and the FIP-UP work program.

The bureau of refugee services shall provide the above services, to the extent compatible with resources available, to persons who entered the United States with refugee status.

441—93.104(239B) Registration and referral requirements. An application for assistance constitutes a registration for the PROMISE JOBS program and the FIA for all members of the FIP case and all other persons responsible for the FIA as specified at 441—41.24(239B) unless the county office determines a person is exempt as specified in 441—subrule 41.24(2).

93.104(1) All registrants may volunteer for services except for persons described at 441—paragraph 41.24(2)*"f."*

93.104(2) Except for persons described at 441—paragraph 41.24(2)*"f,"* applicants for FIP assistance may volunteer for and are eligible to receive job placement services prior to approval of the FIP application. Applicants who participate in the program shall receive a transportation allowance, as well as payment of child care, if required. The transportation allowance shall be paid at the start of participation. The income maintenance worker shall not refer an applicant to the program when it appears that the applicant will be ineligible for FIP.

93.104(3) Applicants in a limited benefit plan who must complete significant contact with or action in regard to PROMISE JOBS for FIP eligibility to be considered, as described at 441—paragraphs 41.24(8)*"a"* and *"d,"* are eligible for expense allowances for the 20 hours of activity. However, PROMISE JOBS services and allowances are only available when it appears the applicant will otherwise be eligible for FIP.

93.104(4) Volunteers and FIP participants who are responsible for the FIA shall contact the appropriate PROMISE JOBS office to schedule an appointment for PROMISE JOBS orientation within ten calendar days of notice that the FIP application is approved or that exempt status is lost and FIA responsibility has begun.

93.104(5) Registrants are exempt from referral when they qualify for exemption as specified in 441—subrule 41.24(1).

93.104(6) Only clients applying for or receiving FIP assistance are eligible for PROMISE JOBS services.

(3) Participation in assessment II and assessment III would interfere with training initiated by the participant after orientation and the training is approvable under PROMISE JOBS. Participants who initiate training after orientation are not considered self-initiated but are otherwise treated in accordance with rule 441—93.108(239B) or in accordance with 93.111(2).

93.111(2) *Assessment-related restrictions on expense allowance assistance for self-initiated training.* When persons described at 93.111(1)*"g"*(2) and (3) are still within the first quarter or semester of involvement with the training program that they have chosen, expense allowance assistance through PROMISE JOBS cannot be approved, even if the training is otherwise approvable, until the persons have completed the assessment II and assessment III options or have successfully completed the first quarter or semester of the training program in accordance with the requirements of the educational institution being attended. Persons involved in training programs where quarters or semesters are not used must successfully complete four months of the training program before assistance can begin, except for SEID and ISHIP participants who are exempt from the limitations of this paragraph. Otherwise, assistance shall only be approved effective with the second quarter or semester, or with the fifth month of participation in the training program, as applicable to the client's situation.

93.111(3) *Requirements for parents aged 19 and younger.* Assessment and development of FIA options shall follow these guidelines for parents under the age of 20.

a. Parents under the age of 16 who have not completed high school shall be expected to use enrollment or continued attendance in high school completion as a first step in the FIA.

b. Parents aged 16 or 17 who have not completed high school shall be expected to use enrollment or continued attendance in high school completion or the GED program as a first step in the FIA. Participants deemed incapable of participating in these activities by the local education agency shall choose other FIA options.

c. Parents who are aged 18 or 19 who have not completed high school shall be expected to use enrollment or continued attendance in high school completion or the GED program as a first step in the FIA if assessment indicates the participants are capable of completing regular high school, alternate high school, or GED. Participants deemed incapable of participating in these activities shall choose other FIA options.

d. For parents aged 19 and younger, the FIA shall include parenting skills training as described at rule 441—93.116(239B) or the case file shall include documentation that this requirement has been fulfilled.

e. For unmarried parents aged 17 and younger, who do not live with a parent or legal guardian, with good cause as described at 441—subrule 41.22(16), the FIA shall include FaDSS, as described at 441—Chapter 165, or other family development services, as described at rule 441—93.119(239B). The FaDSS or other family development services shall continue after the parent is aged 18 only when both the participant and the family development worker believe that the services are needed for the family to reach self-sufficiency.

93.111(4) *Participation after completion of appropriate assessment.* After completion of the appropriate assessment level, participants shall be referred for the PROMISE JOBS component services or supportive services which are designated in the completed FIA.

93.111(5) *Retention of a training slot.* Once a person has been assigned a PROMISE JOBS training slot, that person retains that training slot until FIP eligibility is lost for more than four consecutive months, an LBP chosen after completing an FIA is in effect, or the person becomes exempt from PROMISE JOBS and the person who is eligible to volunteer does not choose to volunteer to continue to participate in the program.

441—93.112(239B) Job search options. Employment is an emphasis of the FIA as described at rule 441—93.109(239B) and PROMISE JOBS participants shall have several options to search for work: job club, individual job search, and self-directed job search. The participant and the PROMISE JOBS workers shall incorporate into the self-sufficiency plan the job search option which is appropriate for the previous work history, skill level, and life circumstances of the participant. Job search contacts shall be documented by PROMISE JOBS staff or by participants, as appropriate. Participant documentation shall be provided as described at 93.135(3). For job search planning and reporting purposes, each in-person job search contact documented by the participant shall be considered to require one hour of participation.

93.112(1) *Job club.* Job club consists of one week of job-seeking skills training and two weeks of group job search. It is expected that job clubs will be designed to require at least 20 hours a week of participation in each week. However, less than 20 hours a week may be scheduled based on local office need and resources. Participants who choose job club shall receive a child care allowance, if required, and an allowance as described at 93.110(6) to cover costs of transportation, if required. The transportation allowance shall be paid in full at the start of participation.

Job-seeking skills training includes, but is not limited to: self-esteem building, goal attainment planning, résumé development, grooming, letters of application and follow-up letters, job application completion, job-retention skills, motivational exercises, identifying and eliminating employment barriers, positive impressions and self-marketing, finding job leads, obtaining interviews, use of telephones, interviewing skills development and practice interviewing.

a. All participants who choose the job club option shall receive one week of job-seeking skills training. Daily attendance during the one week of job-seeking skills training is necessary. Participants who miss any portion of the job-seeking skills training shall repeat the entire week of training.

(1) Participants who must repeat the job-seeking skills training because of absence due to reasons as described at rule 441—93.133(239B) shall receive an additional transportation allowance as described at 93.110(6) and required child care payment shall be made.

(2) Participants who must repeat job-seeking skills training for absence due to reasons other than those described at rule 441—93.133(239B) shall not receive an additional transportation allowance. Required child care payment shall be allowed.

b. Participants shall then take part in a structured employment search activity for a period not to exceed two weeks. Scheduled activities and required hours of participation shall reflect proven job search techniques and the employment environment of the community of the local office and may be varied due to the resources available and the needs of the participants.

Participants who choose job club shall make up absences which occur during the two-week job search period. Additional transportation allowances shall not be paid to these persons. Required child care payments shall be allowed.

c. Job club participants other than designated parents on FIP-UP cases who obtain employment of 86 or more but less than 129 hours per month may discontinue job club if part-time employment was the FIA goal.

d. Job club participants who, during participation, obtain part-time employment of less than 86 hours per month shall continue job club unless the scheduled job club hours conflict with the scheduled hours of employment. PROMISE JOBS participation shall be scheduled to occur during those hours where no conflict with work hours exists.

e. Refer to rule 441—93.122(239B) for job club participation requirements for FIP-UP designated parents.

f. Participants who do not complete the number of job searches required in the period of the job club have chosen the limited benefit plan. Policies at 441—93.132(239B), numbered paragraph "7," rules 441—93.133(239B) and 441—93.134(239B) and subrule 93.138(3) apply.

e. Shall not be used by sponsors to displace current employees or to infringe on their promotional opportunities, shall not be used in place of hiring staff for established vacant positions, and shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

93.121(4) Vocational skills and interests which the registrant possesses shall be matched as closely as possible with the job description and skills requirement specified by the sponsor.

93.121(5) Participants shall interview for and accept positions offered by work experience sponsors. Participants shall present Form WI-3303-0, Referral for WEP Placement, to the sponsor at the interview. The form shall be completed by the sponsor and returned to PROMISE JOBS.

93.121(6) Although sponsors are expected to accept for placement work experience referrals made by PROMISE JOBS, sponsors may refuse any referrals they deem inappropriate for the position which they have available. Sponsors shall not discriminate because of race, color, religion, sex, age, creed, physical or mental disability, political affiliation or national origin against any program participant. Sponsors who refuse a referral must notify PROMISE JOBS staff in writing of the reason for the refusal.

93.121(7) Sponsors shall complete and provide a monthly evaluation of the participant's performance using Form WI-1103-5, Work Experience Participant Evaluation, to PROMISE JOBS and the participant.

93.121(8) Sponsors shall complete Form WI-1103-5, Work Experience Participant Evaluation, at the time of termination for each work experience participant. When termination occurs at sponsor request the sponsor shall specify the reason for termination and identify those areas of individual performance which were unsatisfactory. For participants who leave to accept regular employment or reach their work experience placement time limit, the sponsor's evaluation shall indicate whether or not a positive job reference would be provided if the participant requested one.

93.121(9) Allowances for work experience placements. Participants assigned to work experience shall receive a child care allowance, if required, and a transportation allowance for each month or part thereof as described at subrule 93.110(6). The portion of the transportation allowance for job-seeking activities shall be determined by including the day of the job search obligation in the normally scheduled days used in the formulas described at subrule 93.110(6).

93.121(10) Required clothing and equipment. Clothing, shoes, gloves, and health and safety equipment for the performance of work at a work site under the program, which the participant does not already possess, shall be provided by the entity responsible for the work site or, in the case of safety equipment which the work site entity does not normally provide to employees, through PROMISE JOBS expense allowances. Under no circumstances shall participants be required to use their assistance or their income or resources to pay any portion of their participation costs.

a. Items which are provided by the entity responsible for the work site shall remain the property of the entity responsible for the work site, unless the participant and the entity agree to a different arrangement.

b. Safety equipment which the entity responsible for the work site does not normally provide to employees, including, but not limited to, steel-toed shoes, may be provided through PROMISE JOBS expense allowances up to a limit of $100 per participant per work site assignment. Participants who complete the FIA activity keep the safety equipment. Participants who choose the limited benefit plan shall return all reusable safety equipment, excluding clothing.

441—93.122(239B) FIP-UP work program. When required to meet the federal requirements as described at 93.105(1)*"c,"* one parent from any FIP-UP case shall be enrolled into the FIP-UP work program upon call-up as described at 93.105(2), as one of the FIA options. When both parents are mandatory PROMISE JOBS participants or when one parent is a mandatory participant and one is a volunteer, the PROMISE JOBS worker shall consult with the parents before responsibility is assigned for the FIP-UP work program participation. When one parent is mandatory and one is exempt, the mandatory parent shall fulfill the responsibility for the FIP-UP work program. However, the exempt parent, except for persons described at 441—paragraph 41.24(2)*"f,"* may volunteer for PROMISE JOBS in order to fulfill the responsibility for the FIP-UP work program participation. The parent obligated or chosen to fulfill this responsibility shall be known as the designated parent and the FIA shall include the appropriate FIP-UP work program activities for the designated parent. The designated parent shall complete Form 470-3282, FIP-UP Work Program Designated Parent Declaration, acknowledging that the information in this rule has been provided and that the LBP has been described.

93.122(1) *Activities of the FIP-UP work program.* The FIP-UP work program shall provide orientation, assessment I, job club, unsubsidized employment, and work experience activities for the designated parent.

93.122(2) *Designated parent referral for appropriate activities.* FIP-UP designated parents who do not find employment of 129 hours or more per month before completing job club shall be immediately referred for other appropriate designated parent activities.

93.122(3) *Educational activities for FIP-UP designated parents under the age of 25.*

a. FIP-UP designated parents under the age of 20 who have not completed high school or an equivalent course of education shall meet program participation requirements described at 93.105(1)*"c"* by participating in educational activities such as high school completion and GED as described at subrule 93.111(11) and English as a second language.

b. FIP-UP designated parents aged 20 through 24 who have not completed high school or an equivalent course of education will meet the FIP-UP work program participation requirement if they are participating in educational activities such as high school completion, GED, English as a second language, and adult basic education (ABE) and these activities are included in an FIA.

93.122(4) *Applicable rules.* All rules promulgated under 441—Chapter 93, Division II, shall apply to designated parents on FIP-UP cases unless otherwise noted.

93.122(5) *Work experience assignment for FIP-UP designated parents.* If the FIP-UP designated parent is in unsubsidized employment less than 20 hours per week, the hours of employment can be combined with work experience to total 24 hours per week of participation. If the designated parent is in unsubsidized employment for 20 or more hours per week, work experience is not required.

a. Designated parents on FIP-UP cases shall be assigned to work sites three days per week, eight hours per day, between the hours of 8 a.m. and 6 p.m., Monday through Friday, unless the participant agrees to another schedule, for six-calendar-month periods, at the end of which the participant shall be reassessed and, if appropriate, the designated parent's FIA shall be revised. This revision may include assignment to a different work site, if one is available, or reassignment to the same work site, whichever is appropriate.

b. After each reassessment, a designated parent shall then be reassigned to a work site for another six-calendar-month period.

93.122(6) *Recycling for FIP-UP designated parents.* When a designated parent has completed three six-calendar-month periods of work experience, the designated parent shall be referred to the first available job club activity at workforce development. The participant shall remain in the work experience activity until transfer directly into a job club activity is possible. At the end of the job club activity, the designated parent shall be transferred back to JTPA for assignment to work experience with 30 days of transfer from workforce development.

93.133(1) *Acceptable instances when a person is excused from participation.*

a. Illness. When a participant is ill more than three consecutive days or if illness is habitual, staff may require medical documentation of the illness.

b. Required in the home due to illness of another family member. Staff may require medical documentation for the same reasons as when a participant is ill.

c. Family emergency, using reasonable standards of an employer.

d. Bad weather, using reasonable standards of an employer.

e. Absent or late due to participant's or spouse's job interview. When possible, the participant shall provide notice of the interview at least 24 hours in advance including the name and address of the employer conducting the interview. When 24-hour notice is not possible, notice must be given as soon as possible and prior to the interview.

f. Leave due to the birth of a child. When a child is born after referral, necessary absence shall be determined in accordance with the Family Leave Act of 1993.

93.133(2) *Acceptable instances when a person is excused from participation or for refusing or quitting a job or limiting or reducing hours or for discharge from employment due to misconduct as described at rule 441—93.132(239B).*

a. Required travel time from home to the job or available work experience or unpaid community service site exceeds one hour each way. This includes additional travel time necessary to take a child to a child care provider.

b. Except as described in 441—subrule 41.25(5) and 441—paragraph 42.24(1)"*c,*" work offered is at a site subject to a strike or lockout, unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A) (commonly known as the Taft-Hartley Act), or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160).

c. Violates applicable state or federal health and safety standards or workers' compensation insurance is not provided.

d. Job is contrary to the participant's religious or ethical beliefs.

e. The participant is required to join, resign from or refrain from joining a legitimate labor organization.

f. Work requirements are beyond the mental or physical capabilities as documented by medical evidence or other reliable sources.

g. Discrimination by an employer based on age, race, sex, color, handicap, religion, national origin or political beliefs.

h. Work demands or conditions render continued employment unreasonable, such as working without being paid on schedule.

i. Circumstances beyond the control of the participant, such as disruption of regular mail delivery.

93.133(3) *Jobs that participants have the choice of refusing or quitting or limiting or reducing, or instances when participants are excused for discharge from the job due to misconduct as described at rule 441—93.132(239B).*

a. Employment change or termination is part of the FIA.

b. Job does not pay at least the minimum amount customary for the same work in the community.

c. Employment is terminated in order to take a better-paying job, even though hours of employment may be less than current.

d. The employment would result in the family of the participant experiencing a net loss of cash income. Net loss of cash income results if the family's gross income less necessary work-related expenses is less than the cash assistance the person was receiving at the time the offer of employment is made. Gross income includes, but is not limited to, earnings, unearned income, and cash assistance. Gross income does not include food stamp benefits and in-kind income.

e. The employment changes substantially from the terms of hire, such as a change in work hours, work shift, or decrease in pay rate.

93.133(4) *Instances when problems of participation could negatively impact the client's achievement of self-sufficiency.* There may be instances where staff determine that a participant's problems of participation are not described in 93.133(1) to 93.133(3), but may be circumstances which could negatively impact the participant's achievement of self-sufficiency. When this occurs, the case shall be referred to the administrator of the division of economic assistance for a determination as to whether the problems are acceptable instances for not participating or for refusing or quitting a job or for discharge from employment due to misconduct as described at rule 441—93.132(239B).

441—93.134(239B) Barriers to participation. Problems with participation of a permanent or long-term nature shall be considered barriers to participation and shall be identified in the FIA as issues to be resolved so that participation can result. These barriers may be identified during assessment and shall be part of the FIA from the beginning. When barriers are revealed by the participant during the FIA or are identified by problems which develop after the FIA is signed, the FIA shall be renegotiated and amended to provide for removal of the barriers. FIA-responsible persons who choose not to cooperate in removing identified barriers to participation shall be considered to have chosen the LBP.

Barriers to participation shall include, but not be limited to, the following:

1. Child or adult care is needed before a person can participate or take a job, and the care is not available. Participants are not required to do any activity unless suitable child or adult care has been arranged. In limited instances where special-needs care is not available, it may be most practical for the participant to develop the FIA to identify providing the child or adult care as the FIA option.
2. Lack of transportation.
3. Substance addiction.
4. Sexual or domestic abuse history.
5. Overwhelming family stress.

441—93.135(239B) Required client documentation. Documentation necessary to verify that the PROMISE JOBS participant is carrying out the terms of the FIA shall be provided by the participant.

93.135(1) *Written verification.* The client can be required to provide written verification of family emergency, lack of transportation, or job search activities. It is the responsibility of the client to notify program staff or work site supervisors as soon as possible that a lack of transportation or family emergency has occurred and the expected duration.

93.135(2) *Time and attendance.* The participant's hours of attendance in work and training activities shall be verified monthly.

a. When the participant is in the work experience (WEP) component, the hours of participation shall be verified monthly by the work site, within ten calendar days following the end of each month.

b. Rescinded IAB 3/3/93, effective 5/1/93.

c. When work and training services are provided by training institutions, organizations, agencies, or persons outside of the PROMISE JOBS program, unless some other method is agreed to by the provider and PROMISE JOBS staff, the participant's hours of attendance shall be verified on the PROMISE JOBS Time and Attendance Report, Form 470-2617, which shall be signed and dated by the training provider. When a training provider refuses or fails to verify the hours of attendance, a signed and dated statement from the participant on Form 470-2617 shall be accepted in lieu of a signed statement from the training provider. The form shall be returned by the training provider or client within ten calendar days following the end of each month. In those instances when a training provider refuses or fails to return a completed, signed and dated PROMISE JOBS Time and Attendance Report, Form 470-2617, and it is necessary to request that the form be completed by the participant instead, the participant shall be allowed five working days to provide the form, even if the fifth working day falls on or after the tenth calendar day following the end of the month.

These rules are intended to implement Iowa Code Supplement sections 239B.17 to 239B.22.

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c. Graduation from an accredited four-year college or university with a master's degree in social work or related human service field.

d. Any equivalent combination of graduate education in the social or behavioral sciences from an accredited four-year college or university and qualifying experience up to a maximum of 30 semester hours for one year of the required experience.

108.4(4) *Person filling more than one position.* A person functioning in more than one position specified by these rules shall meet the requirements for each of the positions the person fills.

441—108.5(238) Staffing requirements.

108.5(1) *Number of staff.* The agency shall employ a sufficient number of competent staff to perform duties as required by licensing rules for those programs operated by the agency. This shall include the following:

a. Administration of services offered by the agency.

b. Selection and appointment of qualified staff.

c. Provision for staff training.

108.5(2) *Staffing caseload.* The agency shall develop a written policy regarding a staffing ratio based on the workload necessary to provide services in accordance with the agency's program statements. The staffing ratio shall take into consideration all of the following:

a. Qualifications of the caseworkers.

b. Types of children served and their special needs.

c. Types and intensity of services to be provided.

d. Distances involved in provision of services.

e. Other functions or responsibilities of the caseworkers.

441—108.6(238) Personnel administration.

108.6(1) *Personnel policies.* An agency shall develop personnel policies in writing that identify responsibilities of the organization and staff. The policies shall specify hours of work, grievance procedures, sick leave, vacation and all other benefits. A copy of the policies shall be made available to the employee at time of hire.

108.6(2) *Job description and evaluation.* There shall be a written job description for each employee, volunteer, and contracted position identifying duties, qualifications, education, training requirements, and lines of authority. A copy shall be made available to the employees, volunteers, and contracted workers. There shall be a written evaluation of an employee's or contracted worker's performance within six months of being hired or contracted, and annually thereafter.

108.6(3) *Staff training.* An agency shall provide orientation training on the agency's purpose, policies and procedures within one month of hire and 24 hours of training in the first year of employment for all employed and contracted casework staff. The 24 hours of training shall include: training on family foster care services, adoption services, independent living services, or children and families' mental health topics, and two hours of training related to the identification and reporting of child abuse for all employed or contracted casework staff in accordance with Iowa Code section 232.69. An agency shall provide 12 hours of training per year after the first year of employment for all employed or contracted casework staff. The 12 hours of training shall include: training on family foster care services, adoption services, independent living services, or children and families' mental health topics and child abuse training every five years in accordance with Iowa Code section 232.69.

The training formats that shall qualify as training are as follows: in-service training, seminars, conferences, workshops, institutes, visiting other facilities, and meeting with consultants.

The training provided shall be documented. The documentation shall include the training topic, format, date and number of hours.

108.6(4) *Volunteers.* An agency which utilizes volunteer or student intern staff to work directly with a particular child or group of children shall have a written plan for using these volunteers. This plan shall be given to all volunteer staff and shall indicate that all volunteers are:

a. To be supervised directly by a paid staff member.

b. To be trained and oriented in the philosophy of the agency, the needs of the clients being served, and the methods of meeting these needs.

c. To be subject to the character and reference disclosure and checks required of employed and contracted applicants and employees.

d. To be subject to the same confidentiality rules as paid or contracted staff.

e. To assist and supplement paid staff only, and not replace them.

108.6(5) *Personnel records.* A confidential personnel record shall be maintained for each employee, contracted agent, and volunteer. The record shall contain all of the following information:

a. Name and address.

b. Record of training sessions attended, including dates and content of training.

c. Record of criminal convictions and the department's evaluation of same.

d. Record of founded child abuse reports and the department's evaluation of same.

441—108.7(238) Foster care services.

108.7(1) *Program statement.* An agency authorized to place children in foster care shall have a current written program statement. This statement shall be made available to all agency foster parents, foster children, their parents, referring agencies, and all persons making formal inquiry regarding foster care. The program statement shall include all of the following:

a. Types of foster care provided.

b. Types of children accepted for foster care.

c. Types of services provided to the children, their families, and their foster families.

d. Fees and application costs, if any.

e. A statement informing applicants of the right to appeal the agency's decision regarding nonapproval of the family for placement of a child for foster care.

108.7(2) *Agency's authorization to place.* The agency shall obtain a signed placement agreement from the child's custodial parent or legal custodian within 48 hours of placement.

108.7(3) *Preplacement documentation.* Except for emergency placements, a child shall be placed in the agency's foster care program only after the agency determines that its foster care program is an appropriate resource.

108.7(4) *Placement of siblings.* Preference shall be given to placing children from the same family together. If this is not in the best interest of the child, the reasons shall be documented in the child's record.

108.7(5) *Consideration of racial and cultural identity.* Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

(1) If the applicant, or any other adult living in the home of the applicant, has been convicted of a simple misdemeanor or a serious misdemeanor that occurred five or more years prior to application, the evaluation and decision may be made by the licensed child-placing agency. The licensed child-placing agency shall notify the applicant of the results of the evaluation.

(2) If the applicant, or any other adult living in the home of the applicant, has a founded child abuse report, has been convicted of an aggravated misdemeanor or felony at any time, or has been convicted of a simple or serious misdemeanor that occurred within five years prior to application, the evaluation shall be initially conducted by the licensed child-placing agency.

1. If the licensed child-placing agency determines that the abuse or crime does warrant prohibition of approval, the licensed child-placing agency shall notify the applicant of the results of the evaluation.

2. If the licensed child-placing agency believes that the applicant should be approved despite the abuse or criminal conviction, the licensed child-placing agency shall provide copies of Form 470-2310, Record Check Evaluation, and Form 470-2386, Record Check Decision, to the Department of Human Services, Administrator, Division of Adult, Children and Family Services, Hoover State Office Building, Des Moines, Iowa 50319-0114. Within 30 days, the administrator shall determine whether the abuse or crime merits prohibition of approval, and shall notify the licensed child-placing agency in writing of that decision.

The family shall also be notified by the agency in writing no later than 30 days after completion of the home study of the agency's decision regarding approval for placement of a child. If the family is denied, reasons for denial shall be stated. The adoptive home study shall be dated and signed by the agency worker and supervisor. A copy of the home study shall be provided to the family. An agency shall not place a child in an adoptive home before the family is approved, or before a placement agreement is signed by the family and the agency.

e. A home study update is required if the adoptive home study was written more than one year previously, in accordance with Iowa Code section 600.8. The preplacement assessment update shall be conducted by completing the following:

(1) The child abuse and criminal record checks shall be repeated and any abuses or convictions of crimes since the last record check shall be evaluated using the same process.

(2) A minimum of one home visit shall be conducted with the approved adoptive family.

(3) The information in the approved adoptive home study shall be reassessed.

(4) A written report of the assessment and updated adoptive home study shall be completed, dated, signed by the worker and the supervisor, and provided to the adoptive family.

108.9(5) *Services to adoptive families.*

a. Preparation of the family includes activities designed to prepare the adoptive family for the placement of a particular child. These activities shall assist the adoptive family in expanding its knowledge and understanding of the child and enhance the family's readiness to accept the child into their family and encourage their commitment. The activities shall include, but not be limited to:

(1) Providing background information on the child and the birth family, including a child study that includes past experiences such as foster and adoptive placements.

(2) Providing information regarding the special needs and characteristics of the child.

(3) Providing information regarding an older child's anticipated behavior.

(4) Discussing the impact that adding a new member to their family may have on all current family members.

(5) Discussing the issues of separation, loss, grief, anger, and guilt that adoptive children experience at various developmental stages.

(6) Providing the family with community resources that are available, such as support groups.

b. Preplacement services include the preplacement visits of the child and approved family and any activities necessary to plan, conduct, and assess these transitional visits before the placement of the child in the adoptive family's home for the purpose of adoption.

c. Postplacement services include postplacement supervision, support, crisis intervention, and required reports to the court. The postplacement services are provided from the time the child is placed with an approved adoptive family until finalization of the adoption occurs.

A minimum of three face-to-face postplacement visits are required, or if the family is experiencing problems, as many as are necessary to support the placement. At least two of the visits shall be in the adoptive home. At a minimum the first visit shall be completed within 30 days after placement; the second visit within 90 days after placement; and the final visit before granting consent to adopt.

Observations made during the home visits shall be recorded in the family's adoption file and used by the agency in making written recommendations to the court regarding finalization of the adoption.

Postplacement supervision should focus on the following:

(1) Integration and interaction of the child with the family.

(2) Changes in the family functioning which may be due to the placement.

(3) Social, emotional adjustment of the child and school adjustment of a child who is attending a school.

(4) Child's growth and development since placement with the adoptive family.

(5) Changes that have occurred in the family since the placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

d. Postadoption services. The agency shall provide postadoption services to adoptive parents and adoptees, or shall refer adoptive parents and adoptees to other community resources for the services.

108.9(6) *Placement of siblings.* Preference shall be given to placing children from the same family together. If this is not possible, or is not in the best interest of the children, the reasons shall be documented in the record. Efforts shall be made to provide continued contact between siblings after finalized adoptions if the siblings are not placed together.

108.9(7) *Racial and cultural background.* Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

108.9(8) *Religious policy.* There shall be a written policy on religious participation for prospective placing parents, adoptive parents, and adoptees. The policy shall be made available to referral sources as well.

108.9(9) *Adoption records.* The agency shall keep separate records for each prospective, approved, or active adoptive family. Contents of these records shall be as follows:

a. The application.

b. The adoptive home study.

c. Current medical records.

d. All references.

e. All legal documents pertaining to the adoption.

f. Birth family information and background report, including physical descriptions, medical and mental health history, educational level, developmental history, problem areas such as substance or alcohol abuse.

g. Summary narrative on the placement decision and the preplacement and postplacement contacts with the adoptive family and child.

h. Information pertaining to the child including, but not limited to: physical, medical, and mental health; problem areas, including verification of the child's special needs; and whether or not a referral was made to the department for adoption subsidy.

i. In the event a family is not approved for placement of a child, the narrative shall clearly indicate the reason.

j. In the event a family is approved, but no child is placed with them, the narrative shall clearly indicate the reason.

108.9(10) *Right to appeal.* An adoptive applicant or an adoptive family may appeal an adverse decision made by a licensed agency. The appeal shall be filed with the department within 30 days of the notice of decision to the applicant or family by the licensed agency.

108.9(11) *Disposition of records.* When an adoption has occurred, the agency must maintain all records regarding the child, the birth family, and the adoptive family or families, forever. Any subsequent information received following the adoption finalization shall be placed in the adoption record. If the agency closes, all adoption records shall be forwarded to the department.

441—108.10(238) Independent living placement services. An agency seeking to obtain a child-placing license which authorizes the agency to place or supervise children in independent living placements shall meet the standards in rules 108.2(238) to 108.6(238).

108.10(1) *Program statement.* An agency authorized to place or supervise children in independent living placements shall have a current written program statement which includes all of the following:

a. A description of the types of living arrangements approved by the agency.

b. The eligibility requirements for the children who may be placed in an independent living placement.

c. The means of financial support for the children.

d. The expectations the agency has for children while placed in an independent living placement.

e. Services provided to the children.

f. Provisions for emergency medical care.

This program statement shall be provided to all children placed in independent living.

108.10(2) *Basis for placement.* Before placing a child in independent living, an agency shall document all of the following:

a. The child is at least 16 years of age.

b. An initial assessment has been made that identifies the child's strengths and needs as these pertain to the child's ability to live independently.

c. The child has the capacity to function outside the structure of a foster family or group care setting.

d. The selection of an independent living placement is the most appropriate placement for the child.

e. The child shall be involved in school or other educational or vocational program, work, or a combination thereof on a full-time basis, as indicated in the child's individual care plan.

f. The child has entered into a mutually agreed-upon written contract with the agency which specifies the responsibilities of the agency and the child. This contract shall be reviewed quarterly.

g. It has been determined, through a visit to the living arrangement, that the minimum standards for approval have been met.

108.10(3) *Services provided.* The following services are required:

a. Ongoing assessment that identifies child's strengths and needs as these pertain to the child's ability to live independently.

b. The development of an individual service plan within 30 days of placement. The service plan shall be developed in consultation with the child and referring agent. The individual service plan shall include projection of the expected length of stay in supervised independent living and shall address the activities necessary to achieve independence and the services needed to be provided to the child. The individual service plan shall be updated quarterly.

c. At least weekly face-to-face contacts with the child for the first 60 days of placement and at least twice a month face-to-face contact thereafter. Frequency of visits shall be based on the needs of the individual child.

d. Personal observation by the agency worker that the living situation provides safe and suitable social, emotional, and physical care.

e. Maintenance of a means by which the youth can contact agency personnel 24 hours a day, seven days a week.

108.10(4) *Record.* An agency shall maintain a record for each child in an independent living placement. The record shall contain all of the following:

a. The name, date of birth, sex, and address of the child and information on how the child can be contacted.

b. Documentation of financial support sufficient to meet the child's housing, clothing, food, and miscellaneous expenses.

c. Name, address, and phone number of guardian, if applicable, and referring agent.

d. Medical records.

e. Educational and employment records.

f. All of the individual service plans and updated reviews.

g. Documentation of visits.

108.10(5) *Staffing requirements.* Each child in an independent living placement shall receive an agreed-upon number of hours of casework services per month. This shall be recorded in the child's individual service plan.

These rules are intended to implement Iowa Code chapter 238.

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d. Any appropriate evaluations or testing.

e. HIV testing of a child by the University of Iowa Hospital or a local physician when any of the following conditions exist:

(1) The child was, or may have been, sexually abused by a person who participated in high-risk behavior such as sharing of needles with an infected person or sex participation with an infected person.

(2) The child's birth mother participated in high-risk behavior, or is HIV positive.

(3) The child participated in, or has participated in, high-risk behavior.

(4) The child is symptomatic or at high risk of infections.

(5) The child received blood products prior to 1986 or the birth parents received blood products prior to 1986, before or during pregnancy.

(6) There is a lack of medical information regarding the birth parents or the child.

200.4(3) *Selection of family.* This component includes the activities necessary to select the family which can best meet the needs of the adoptive child.

Prior to preplacement visits a staffing of the child shall be held to select an approved family. A minimum of two social workers and a supervisor shall be included in the staffing. The child's special needs, characteristics, and anticipated behaviors shall be reviewed in the staffing to determine a family that can best meet the needs of the child. Approved families shall also be reviewed in an effort to match the specific family's parenting strengths with a particular child's needs.

The following selection criteria shall be observed:

a. Preference shall be given to placing children from the same birth family together. If placement together is not possible, or is not in the best interest of the children, the reasons shall be identified and documented in each child's case record. Efforts shall be made to ensure continuous contact between siblings when the siblings are not placed together.

b. Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

c. A child who is sexually active and at risk of or is HIV positive shall not be placed in a family where other children reside due to the risk of transmission.

200.4(4) *Preparation of family.* This component includes activities designed to assist the adoptive family in expanding its knowledge and understanding of the child or children. This component should enhance the family's readiness to accept the child or children into their family and encourage their commitment. The activities shall include, but are not limited to:

a. Completion of at least 12 hours of the department's designated preservice training for foster parents, 12 hours of the department's designated adoption training, and the Universal Precautions in Foster and Adoptive Family Homes course prior to placement of a child. These training requirements apply to families who are adopting special needs children who are under the guardianship of the department. Foster parents who have been caring for a foster child in their home for at least six months and who have been selected to adopt that child may have their participation in adoption training waived by the human services area administrator or designee. Relatives who have cared for a related child for at least six months and who have been selected to adopt that relative child may have their participation in the department's preservice training for foster parents or the designated adoption training waived by the human services area administrator or designee. Adoptive families approved for adoption prior to June 1, 1997, shall not be required to complete the department's designated adoption training. If the family is accepting placement of a child who is at high risk of, or is HIV positive, they shall also complete the Caring for Children With HIV course.

b. Discussion with family members regarding problems resulting from a child's separation, loss, grief, and anger due to the loss of the birth parents.

c. Provision of background information on the child and birth family, including a child study that includes experiences such as foster and adoption placements and other pertinent information and the child's life book.

d. Provision of information regarding the child's special needs and behavior patterns.

e. Provision of a description of the child's medical needs, including whether or not the child is at risk of or is HIV positive.

f. Discussion of the impact that adding a new member or members to the family may have on all current family members.

g. Explanation of the subsidized adoption program.

h. Provision of information regarding the community resources that are available to assist the family, such as parent support groups.

200.4(5) *Preplacement visits.* This component includes activities necessary to plan, conduct and assess the transitional visits between the adoptive family and the child or children prior to the adoptive placement of the child in the home.

200.4(6) *Placement services.* Placement services include the activities necessary to plan and carry out the placement of a child or children into the adoptive family.

Prior to placement of a child, the Agreement of Placement for Adoption, Form SS-6623, shall be signed by all parties.

200.4(7) *Postplacement services.* Postplacement services include supervision, support, crisis intervention and required reports. Postplacement supervision is provided from the time a child is placed with an adoptive family until finalization of the adoption occurs.

a. Postplacement supervision shall focus on the following areas:

(1) Integration and interaction of the child or children with the family.

(2) Changes in the family functioning which may be due to the placement.

(3) Social and emotional adjustment of the child or children.

(4) School adjustment of the child or children who are attending school.

(5) Changes and adjustments that have been made in the family since the placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Child's growth and development since placement in the family.

(8) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

b. A minimum of three adoptive home visits are required or, if the family is experiencing problems, as many as are necessary to assess and support the placement.

Home visits shall be completed at a minimum as follows: one no later than 30 days after placement, one no later than 90 days after placement, and a final visit prior to requesting a consent to adopt. Supervisory reports based on observations shall be completed after the home visits using Form SS-6713, Supervisory Report.

A consent to adopt may be rescinded by the department, by signing Rescinding the Consent to Adoption, Form 470-2990, for any of the following reasons:

1. At the request of the adoptive family.
2. A founded child abuse report, or accusation of child abuse, pending determination of the report.
3. Conviction of a crime, or accusation of a crime, pending a court decision regarding the crime.
4. At the request of a child who is aged 14 or over and has reversed the decision regarding the adoption.
5. Other verified indications that the adoption is not in the best interest of the child.

441—200.14(600) Requests for access to information for research or treatment.

200.14(1) *Requests.* Any person seeking access to the department's sealed adoption records for the purpose or purposes set forth in Iowa Code paragraph 600.16(1)"*c*" or Iowa Code subsection 600.24(2) shall submit a request in writing to the director. Each request shall contain sufficient facts to establish that the information sought is necessary for conducting a legitimate medical research project, or for treating a patient in a medical facility.

200.14(2) *Process.* Upon receipt of a request for information sought in conducting a research project, the director or a designee shall review the request for information and make a decision to approve, or deny, the request based on the research to be conducted, the benefits of the research, the methodology, and the confidentiality measures to be followed. Upon a request for information for treating a patient in a medical facility, a decision regarding approval or denial shall be made by the director or designee based on the written information provided by a physician or the medical facility, making the request. Requesters shall be notified in writing of approval or denial and if denied, reasons for denial given.

441—200.15(600) Requests for information for other than research or treatment. Requests for information from department adoption records for other than research or treatment shall be made to the Department of Human Services, Division of Adult, Children and Family Services, Adoption Program, Hoover State Office Building, Des Moines, Iowa 50319-0114.

The department shall not release identifying information from sealed adoption records. Adult adoptees, adoptive parents, birth parents, siblings or descendants of an adopted person, or legal representatives of any of the above shall be provided an adoption packet containing a sample affidavit for filing with the court, directions for filing the affidavit, a list of county clerks of court and the address of the bureau of vital statistics which retains the name of the county where their adoption was finalized in Iowa.

An adopted person who was a resident of the Annie Wittenmeyer Home (Iowa Soldier's and Sailor's Home) may receive nonidentifying information from Annie Wittenmeyer records if the information is available.

441—200.16(600) Appeals. Prospective adoptive families may appeal denial of approval of their home study based on rule 441—200.11(600), pursuant to 441—Chapter 7.

These rules are intended to implement Iowa Code chapter 600.

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202.3(2) When the voluntary placement is of a child who is under the age of 18 a Voluntary Foster Care Placement Agreement, Form SS-2604, shall be completed and signed by the parent(s) or guardian and the county office where the parent or guardian resides. Voluntary Foster Care Placement Agreements shall not be used to place children outside Iowa and shall not be signed with parents or guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's parent or guardian moves outside Iowa after the placement.

202.3(3) Voluntary placement of a child aged 18 or older may be granted for six months at a time only when the child meets the definition of "child" in subrule 202.1(3), was in foster care or a state institution immediately prior to reaching the age of 18, has continued in foster care or a state institution since reaching the age of 18, and has demonstrated a willingness to participate in case planning and to fulfill responsibilities as defined in the case plan. Payment shall be limited pursuant to 441—paragraph 156.20(1)*"b."*

a. When the voluntary placement is of a child who is aged 18 or older and who has a court-ordered guardian, the Voluntary Foster Care Placement Agreement, Form SS-2604, shall be completed and signed by the guardian and the county office where the guardian resides. Voluntary Foster Care Placement Agreements shall not be used to place children outside Iowa and shall not be signed with guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's guardian moves outside Iowa after the placement.

b. When the voluntary placement is of a child who is aged 18 or older and who does not have a court-appointed guardian, the Voluntary Foster Care Placement Agreement, Form SS-2604, shall be completed and signed by the child and the county office where the child resides.

202.3(4) All voluntary placements shall be approved by the regional administrator or designee.

This rule is intended to implement Iowa Code section 234.6(6)*"b"* and 1992 Iowa Acts, House File 2480, sections 11 and 12.

441—202.4(234) Selection of facility.

202.4(1) Placement consistent with the best interests and special needs of the child shall be made in the least restrictive, most family-like facility available and in close proximity to the child's home. Race, color, or national origin may not be routinely considered in placement selections.

202.4(2) Efforts shall be made to place siblings together unless to do so would be detrimental to any of the children's physical, emotional or mental well-being. Efforts to prevent separating siblings, reasons for separating siblings, and plans to maintain sibling contact shall be documented in the child's case permanency plan.

202.4(3) Staff shall consider placing the child in a relative's home unless to do so would interfere with the permanency plan for the child, no relatives are available or willing to accept placement, or to do so would be detrimental to the child's physical, emotional or mental well-being. Efforts to place the child in a relative's home and reasons for using a nonrelative placement shall be documented in the child's case permanency plan.

202.4(4) If the child cannot be placed with a relative, foster family care shall be used for a child unless the child has problems requiring specialized service which cannot be provided in a family setting. Reasons for using a more restrictive placement shall be documented in the child's case permanency plan.

202.4(5) A foster family shall be selected on the basis of compatibility with the child, taking into consideration:

a. The extent to which interests, strengths, abilities and needs of the foster family enable the foster family members to understand, accept and provide for the individual needs of the child.

b. The child's individual problems, medical needs, and plans for future care.

c. The capacity of the foster family to understand and accept the child's case permanency plan, the needs and attitudes of the child's parents, and the relationship of the child to the parents.

d. The characteristics of the foster family that offer a positive experience for the child who has specific problems as a consequence of past relationships.

e. An environment that will cause minimum disruption of the child including few changes in placement for the child.

f. The treatment needs of the child as determined by the review organization pursuant to rule 441—185.2(234).

202.4(6) A foster group care facility shall be selected on the basis of its ability to meet the needs of the child, promote the child's growth and development, and ensure physical, intellectual and emotional progress during the stay in the facility. The department shall place a child only in a licensed or approved facility which has a current purchase of service contract with the department.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.5(234) Preplacement.

202.5(1) Except for emergency foster care, a child placed in a facility shall have a preplacement visit involving the child, the foster parents or agency staff if the child is placed in a public or private agency, and the service worker. The parents shall be included in the preplacement visit unless their presence would be disruptive to the child's placement.

202.5(2) Prior to placement, the worker shall provide the facility with general information regarding the child, including a description of the child's medical needs, behavioral patterns, educational plans, and permanency goal.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.6(234) Placement.

202.6(1) At the time of placement, the worker shall provide the facility with specific information regarding the child including the case permanency plan, the results of a physical examination, the child's medical needs including special needs of HIV, behavioral patterns, and educational arrangements, the placement contract or agreement, and medical authorizations, service authorizations, and other releases as needed.

Prior to releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information. Form 470-3227, Receipt of HIV-Related Information, shall be completed by the person receiving this information to document understanding of the confidentiality of this knowledge.

Form 470-3226, HIV General Agreement, shall be completed by foster parents who have agreed to care for children who have AIDS, test HIV positive, or are at risk for HIV infection.

202.6(2) For placement in a foster family home supervised directly by department staff, Form SS-2605-0, Foster Family Placement Contract, shall be completed by the provider and department representatives. A new foster family placement contract shall be completed when the rate of payment or special provisions change.

202.6(3) A follow-up visit shall be made to the child at the foster family home within two weeks of the initial placement for placements supervised directly by the department.

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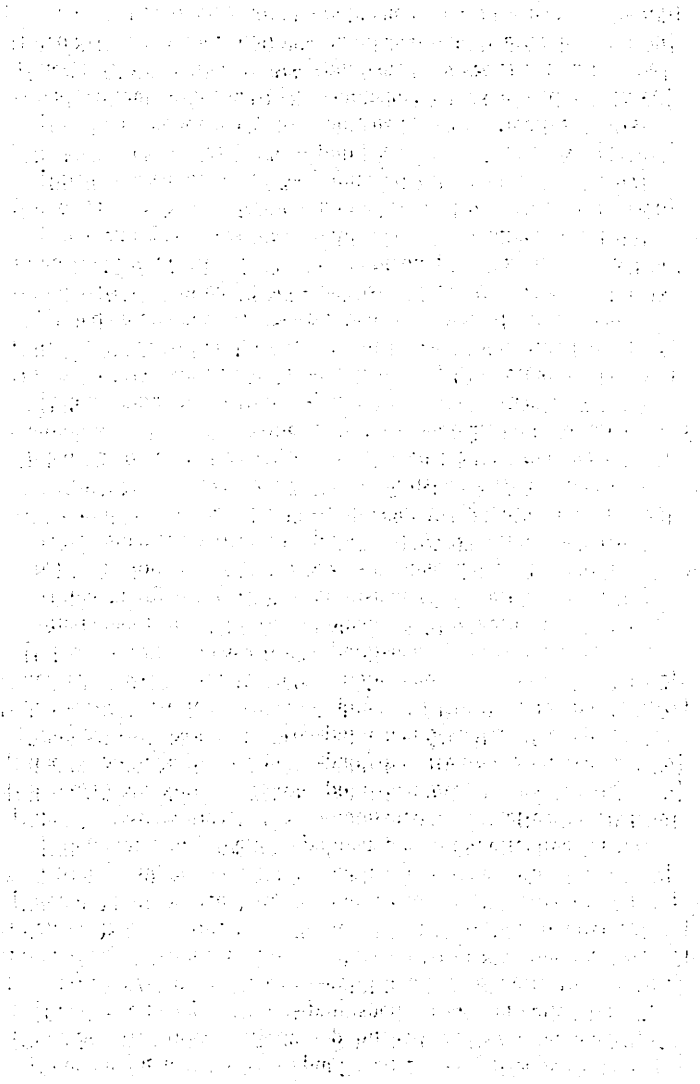

f. Provides for an annual evaluation by the governing board of the effectiveness of the quality improvement program; and

g. Addresses accessibility and confidentiality of materials relating to, generated by or part of the quality improvement process.

This rule is intended to implement Iowa Code chapter 135B.

481—51.4(135B) Governing board. The governing board or the owner or the person or persons designated by the owner as the governing authority shall be the supreme authority in the hospital, responsible for the management, control, and appointment of the medical staff and functioning of the institution subject to the laws of the state of Iowa. The governing board shall appoint a medical staff which shall consist of one or more licensed physicians who shall be responsible to the governing authority for the clinical and scientific work of the hospital.

481—51.5(135B) Medical staff.

51.5(1) A roster of medical staff members shall be kept.

51.5(2) All hospitals shall have one or more licensed physicians designated for emergency call service at all times.

51.5(3) A hospital shall not deny clinical privileges to physicians and surgeons, podiatrists, osteopaths or osteopathic surgeons, dentists, certified health service providers in psychology, physician assistants or advanced registered nurse practitioners licensed under Iowa Code chapter 148, 148C, 149, 150, 150A, 152, or 153 or section 154B.7 solely by reason of the license held by the practitioner or solely by reasons of the school or institution in which the practitioner received medical schooling or postgraduate training if the medical schooling or postgraduate training was accredited by an organization recognized by the council on postsecondary accreditation or an accrediting group recognized by the United States Department of Education.

51.5(4) A hospital shall establish and implement written criteria for the granting of clinical privileges. The written criteria shall include, but not be limited to, consideration of the:

a. Ability of the applicant to provide patient care services independently or appropriately in the hospital;

b. License held by the applicant to practice;

c. Training, experience, and competence of applicant;

d. Relationship between the applicant's request for privileges and the hospital's current scope of patient care services;

e. Applicant's ability to provide comprehensive, appropriate and cost-effective services.

481—51.6(135B) Patient rights and responsibilities. The hospital governing board shall adopt a statement of principles relating to patient rights and responsibilities. In developing a statement of principles, the hospital may use reference statements of patient rights and responsibilities developed by the American Hospital Association, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA), and other appropriate sources.

51.6(1) The statement of principles shall be made available to patients of the hospital.

51.6(2) The statement of principles regarding patient rights shall, at a minimum, address:

a. Access to treatment regardless of race, creed, sex, national origin, diagnosis, or source of payment for care;

b. Preservation of individual dignity and protection of personal privacy in receipt of care;

c. Confidentiality of medical and other appropriate information;

d. Assurance of reasonable safety within the hospital;

e. Knowledge of the identity of the physician or other practitioner primarily responsible for the patient's care as well as identity and professional status of others providing services to the patient while in the hospital;

f. Nature of patient's right to information regarding the patient's medical condition unless medically contraindicated, to consult with a specialist at the patient's request and expense, and to refuse treatment to the extent authorized by law;

g. Access to and explanation of patient billings; and

h. Process for patient pursuit of grievances.

51.6(3) The statement of principles regarding patient responsibilities shall, at a minimum, address:

a. Need of patient to provide accurate and complete information regarding the patient's health status;

b. Need of patient to follow recommended treatment plans;

c. Requirement that patient abide by hospital rules and regulations affecting patient care and conduct and be considerate of the rights of other patients and hospital personnel; and

d. Obligation to fulfill the patient's financial obligations as soon as possible following discharge.

This rule is intended to implement Iowa Code chapter 135B.

481—51.7(135B) Abuse.

51.7(1) *Definitions.*

a. Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

b. Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment.

c. Sexual abuse includes, but is not limited to, the exposing of pubes to a patient, and the exposure of a patient's genitals, pubes, breasts or buttocks, fondling or touching the inner thigh, groin, buttocks, anus, or breast of a patient or the clothing covering these areas for sexual satisfaction, sexually suggestive comments or remarks made to a patient, a genital-to-genital or oral-to-genital contact or the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2.

d. Domestic abuse, as defined in Iowa Code section 236.2, means the commission of assault under either of the following circumstances:

(1) The assault is between family or household members who resided together at the time of the assault; or

(2) The assault is between separated spouses or persons divorced from each other and not residing together at the time of the assault.

e. Family or household members, as defined in Iowa Code section 236.2, are spouses, persons cohabiting, parents, or other persons related by consanguinity or affinity, except children under the age of 18.

51.7(2) *Abuse prohibited.* Each patient shall receive kind and considerate care at all times and shall be free from mental, physical, and sexual abuse.

a. Restraints shall be applied only when they are necessary to prevent injury to the patient or to others and shall be used only when alternative measures are not sufficient to accomplish their purposes.

51.51(8) *Radiology suite.* The suite shall be designed and equipped in accordance with the following references:

a. National Council on Radiation Protection and Measurements Reports (NCRP), Nos. 33 and 49.

b. Iowa department of public health 641—Chapters 38 to 41.

51.51(9) *Waste processing services—storage and disposal.* In lieu of the waste processing service requirements in the "Guidelines for Construction and Equipment of Hospital and Healthcare Facilities" in paragraph 51.51(2)*"a,"* space and facilities shall be provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, compaction, containerization, removal or a combination of these techniques. These techniques must comply with the following environmental protection commission rules: rules 567—64.2(455B) and 64.3(455B); solid waste requirements of rules 567—101.1(455B,455D), 102.1(455B), 104.1(455B), and 567—Chapters 106, 118 and 119; and air quality requirements of 567—subrules 22.1(1) and 23.4(12).

51.51(10) *Codes and standards.* See 481—subrule 51.50(10).

481—51.52(135B) Critical access hospitals. Critical access hospitals shall meet the following criteria:

51.52(1) The hospital shall be no less than 35 miles from another hospital or no less than 15 miles over secondary roads or shall be designated by the department of public health as a necessary provider of health care.

51.52(2) The hospital shall be a public or nonprofit hospital and shall be located in a county in a rural area.

51.52(3) The hospital shall provide 24-hour emergency care services as described in 481 IAC 51.30(135B).

51.52(4) The hospital shall maintain no more than 15 acute care inpatient beds or, in the case of a hospital having a swing-bed agreement, no more than 25 inpatient beds; and the number of beds used for acute inpatient services shall not exceed 15 beds.

51.52(5) The hospital shall meet the Medicare conditions of participation as a critical access hospital as described in 42 CFR Part 485, Subpart F as of October 1, 1997.

51.52(6) The hospital shall continue to comply with all general hospital license requirements as defined in 481 IAC 51.

These rules are intended to implement Iowa Code chapter 135B.

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◊Three ARCs
††Two ARCs

CHAPTER 21
IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
[Prior to 5/6/87, Employment Security[370]Ch 8]

581—21.1(97B) Organization. The Iowa public employees' retirement system was created by Iowa Code chapter 97B.

21.1(1) *Definitions.* Unless otherwise prescribed by federal or state regulations, the terms used in this chapter shall have the following meanings:

"Board" means the investment board of IPERS established in Iowa Code section 97B.8.

"Chief benefits officer" means the person employed by the director to administer the benefits programs of the retirement system.

"Chief investment officer" means the person employed by the director to administer the investment program of the retirement system.

"Department" means the Iowa department of personnel.

"Director" means the director of the Iowa department of personnel.

"Internal Revenue Code" means the Internal Revenue Code as defined in Iowa Code section 422.3.

"IPERS" means the Iowa public employees' retirement system.

21.1(2) *Administration.* The director, through the chief investment officer and the chief benefits officer, shall administer Iowa Code chapters 97, 97B, and 97C, shall execute contracts on behalf of IPERS, shall make expenditures, reports, and investigations as necessary to carry out the powers and duties created in Iowa Code chapter 97B, and may obtain as necessary the specialized services of individuals or organizations on a contract-for-services basis.

21.1(3) *Location.* Beginning August 28, 2000, IPERS' business location is 7401 Register Drive, Des Moines, Iowa. General correspondence, inquiries, requests for information or assistance, complaints, or petitions shall be addressed to: Iowa Public Employees' Retirement System, P.O. Box 9117, Des Moines, Iowa 50306-9117.

21.1(4) *Business hours.* Business hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays.

21.1(5) *Investment board.*

a. The board shall meet annually, and may meet more often, to review its investment policies. Future meeting dates shall be set by members of the board at the end of each meeting.

b. At the first meeting in each fiscal year, the voting members shall elect a chair and vice-chair.

c. Beginning August 28, 2000, the principal place of business of the investment board is 7401 Register Drive, Des Moines, Iowa.

d. Advance notice of time, date, tentative agenda, and place of each meeting shall be given in compliance with Iowa Code chapter 21.

e. Parties wishing to present items for the board's agenda for its next meeting shall file a written request with IPERS at least five workdays prior to the meeting. The board may take up matters not included on its agenda.

f. Quorum. Five members eligible to vote shall constitute a quorum. A simple majority vote of the full voting membership shall be the vote of the board.

g. In the event that it should become necessary to fill the chief investment officer position, the board may consult with, and make hiring recommendations to, the director.

581—21.2(97B) Records to be kept by the employer.

21.2(1) *Definition.* Each employing unit shall maintain records to show the information hereinafter indicated. Records shall be kept in the form and manner prescribed by IPERS. Records shall be open to inspection and may be copied by IPERS and its authorized representatives at any reasonable time.

21.2(2) *Records shall show with respect to each employee:* the employee's name, address and social security account number; each date the employee was paid wages or other wage equivalent (e.g., room, board); the total amount of wages paid on each date including noncash wage equivalents; the total amount of wages including wage equivalents on which IPERS contributions are payable; and the amount withheld from wages or wage equivalents for the employee's share of IPERS contributions.

Effective January 1, 1995, records will show, with respect to each employee, member contributions picked up by the employer.

21.2(3) *Reports.* Each employing unit shall make reports as IPERS may require, and shall comply with the instructions printed upon any report form issued by IPERS pertaining to the preparation and return of the report. Effective July 1, 1991, employers must report all terminating employees to IPERS within seven working days following the employee's termination date. This report to IPERS shall contain the employee's last-known mailing address and such other information as IPERS might require.

21.2(4) *Fees.* IPERS may assess to an employer a fee based on IPERS' cost accrued in correcting an employer's errors if an employer fails to file required documents and remittances accurately.

This rule is intended to implement Iowa Code sections 97B.11, 97B.14 and 97B.53A.

581—21.3(97B) Liable employers.

21.3(1) *Definition.* All public employers in the state of Iowa, its cities, counties, townships, agencies, political subdivisions, instrumentalities and public schools are required to participate in IPERS. For the purposes of these rules, the following more specific definitions also apply:

a. *"Political subdivision"* means a geographic area or territorial division of the state which has responsibility for certain governmental functions. Political subdivisions are characterized by public election of officers and taxing powers. The following examples are representative: municipalities, counties, school districts, drainage districts, and utilities.

b. *"Instrumentality of the state or a political subdivision"* means an independent entity that is organized to carry on some specific function of government. Public instrumentalities are created by some form of governmental body, including federal and state statutes and regulations, and are characterized by being under the control of a governmental body. Such control may include final budgetary authorization, general policy development, appointment of a board by a governmental body, and allocation of funds.

c. *"Public agency"* means state agencies and agencies of political subdivisions. Representative examples include an executive board, commission, bureau, division, office, or department of the state or a political subdivision.

d. Effective July 1, 1994, the definition of employer includes an area agency on aging that does not offer an alternative plan to all of its employees that is qualified under the federal Internal Revenue Code.

Some employers included are: the state of Iowa and its administrative agencies; counties, including their hospitals and county homes; cities, including their hospitals, park boards and commissions; recreation commissions; townships; public libraries; cemetery associations; municipal utilities including waterworks, gasworks, electric light and power; school districts including their lunch and activity programs; state colleges and universities; and state hospitals and institutions. Any employing unit not already reporting to IPERS which fulfills the conditions with respect to becoming an employer shall immediately give notice to IPERS of that fact. Such notice shall set forth the name and address of the employing unit.

21.3(2) *Name change.* Any employing unit which has a change of name, address, title of the unit, its reporting official or any other identifying information shall immediately give notice in writing to IPERS. The notice shall include the former name, address and IPERS account number of the employing unit, the new name and address of the employing unit and the reason for the change if other than a change of reporting official.

j. Wages for certain testing purposes. Wages for testing purposes to ensure compliance with Internal Revenue Code Section 415 shall include a member's gross wages, excluding nontaxable fringe benefits and all amounts placed in tax-deferred vehicles including, but not limited to, plans established pursuant to Internal Revenue Code Sections 125, 401(k), 403, and 457, and excluding IPERS contributions paid after December 31, 1994, by employers on behalf of employees. Effective January 1, 1996, the annual wages of a member taken into account for testing purposes under any of the applicable sections of Internal Revenue Code shall not exceed the applicable amount set forth in Internal Revenue Code Section 401(a)(17), and any regulations promulgated pursuant to that section. The foregoing sentence shall not be deemed to permit the maximum amount of wages of a member taken into account for any other purpose under Iowa Code chapter 97B to exceed the maximum covered wage ceiling under Iowa Code section 97B.1A(25). Effective January 1, 1998, wages for testing purposes to ensure compliance with Internal Revenue Code Section 415 shall include elective deferrals placed in tax-deferred plans established pursuant to Internal Revenue Code Sections 125, 401(k), 403, and 457 by employers on behalf of employees.

21.4(2) Wages are reportable in the quarter in which they are actually paid to the employee, except in cases where employees are awarded lump sum payments of back wages, whether as a result of litigation or otherwise, in which case the employer shall file wage adjustment reporting forms with IPERS allocating said wages to the periods of service for which such payments are awarded. Employers shall forward the required employer and employee contributions and interest to IPERS.

An employer cannot report wages as having been paid to employees as of a quarterly reporting date if the employee has not actually or constructively received the payments in question. For example, wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on June 30 would be reported as second quarter wages, but wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on July 3 would be reported as third quarter wages.

IPERS contributions must be calculated on the gross amount of a back pay settlement before the settlement is reduced for taxes, interim wages, unemployment compensation, and similar mitigation of damages adjustments. IPERS contributions must be calculated by reducing the gross amount of a back pay settlement by any amounts not considered covered wages such as, but not limited to, lump sum payments for medical expenses.

Notwithstanding the foregoing, a back pay settlement that does not require the reinstatement of a terminated employee and payment of the amount of wages that would have been paid during the period of severance (before adjustments) shall be treated by IPERS as a "special lump sum payment" under subrule 21.4(1) above and shall not be covered.

21.4(3) One quarter of service will be credited for each quarter in which a member is paid covered wages.

a. "Covered wages" means wages of a member during periods of service that do not exceed the annual covered wage maximum. Effective January 1, 2000, and for each subsequent calendar year, covered wages shall not exceed $170,000 or the amount permitted for that year under Section 401(a)(17) of the Internal Revenue Code.

b. Effective January 1, 1988, covered wages shall include wages paid a member regardless of age. (From July 1, 1978, until January 1, 1988, covered wages did not include wages paid a member on or after the first day of the month in which the member reached the age of 70.)

c. If a member is employed by more than one employer during the calendar year, the total amount of wages paid shall be included in determining the annual covered wage maximum. If the amount of wages paid to a member by several employers during a calendar year exceeds the covered wage limit, the amount of the excess shall not be subject to contributions required by Iowa Code section 97B.11. See subrule 21.8(1), paragraph *"h."*

This rule is intended to implement Iowa Code section 97B.1A(25).

581—21.5(97B) Identification of employees covered by the IPERS retirement law.

21.5(1) Definition of employee.

a. A person is in employment as defined by Iowa Code chapter 97B if the person and the covered employer enter into a relationship which both recognize to be that of employer/employee. A person is not in employment if the person volunteers services to a covered employer for which the person receives no remuneration. An employee is an individual who is subject to control by the agency for whom the individual performs services for wages. The term control refers only to employment and includes control over the way the employee works, where the employee works and the hours the employee works. The control need not be actually exercised for an employer/employee relationship to exist; the right to exercise control is sufficient. A public official may be an "employee" as defined in the agreement between the state of Iowa and the Secretary of Health, Education and Welfare, without the element of direction and control.

Effective July 1, 1994, a person who is employed in a position which allows IPERS coverage to be elected as specified in Iowa Code section 97B.1A(8) must file a one-time election form with IPERS for coverage. If the person was employed before July 1, 1994, the election must be postmarked on or before July 1, 1995. If the person was employed on or after July 1, 1994, the election must be postmarked within 60 days from the date the person was employed. Coverage will be prospective from the date the election is approved by IPERS. The election, once filed, is irrevocable and membership continues until the member terminates covered employment. The election window does not allow members who had been in coverage to elect out.

Effective July 1, 1994, members employed before that date as a gaming enforcement officer, a fire prevention inspector peace officer, or an employee of the division of capitol police (except clerical workers), may elect coverage under Iowa Code chapter 97A in lieu of IPERS. The election must be directed to the board of trustees established in Iowa Code section 97A.5 and postmarked on or before July 1, 1995. Coverage under IPERS will terminate when the board of trustees approves the election. The election, once received by the board of trustees, is irrevocable. If no election is filed by that date, the member will remain covered by IPERS until termination of covered employment. The election window does not allow a member who previously elected out of IPERS to reverse the decision and become covered under IPERS.

Effective January 1, 1999, new hires who may elect out of IPERS coverage shall be covered on the date of hire and shall have 60 days to elect out of coverage in writing using IPERS' forms. Notwithstanding the foregoing, employees who had the right to elect IPERS coverage prior to January 1, 1999, but did not do so, shall be covered as of January 1, 1999, and shall have until December 31, 1999, to elect out of coverage.

Employment as defined in Iowa Code chapter 97B is not synonymous with IPERS membership. Some classes of employees are excluded under Iowa Code section 97B.1A(8)*"b"* from membership by their nature. The following subparagraphs are designed to clarify the status of certain employee positions.

(1) Effective January 1, 1999, elected officials in positions for which the compensation is on a fee basis, elected officials of school districts, elected officials of townships, and elected officials of other political subdivisions who are in part-time positions are covered by IPERS unless they elect out of coverage. An elected official who becomes covered under this chapter may later terminate membership by informing IPERS in writing of the expiration of the member's term of office, or if a member of the general assembly, of the intention to terminate coverage. An elected official does not terminate covered employment with the end of each term of office if the official has been reelected for the same position. If elected for another position, the official shall be covered unless the official elects out of coverage.

(2) County and municipal court bailiffs who receive compensation for duties are included.

(3) City attorneys are included.

(4) Judicial magistrates are included unless they elect out of IPERS coverage. Having made a choice to remain in IPERS coverage, a judicial magistrate may not revoke that election and discontinue such coverage.

(5) Office and clerical staff of a county medical examiner's office are included, but county medical examiners and deputy county medical examiners are excluded.

(6) Effective July 1, 1994, police officers and firefighters of a city not participating in the retirement systems established under Iowa Code chapter 410 or 411 are included. Emergency personnel, such as ambulance drivers, who are deemed to be firefighters by the employer, are to be treated as firefighters. Effective January 1, 1995, part-time police officers are covered in the same manner as full-time police officers. In accordance with Iowa Code section 80D.14, reserve peace officers employed under Iowa Code chapter 80D are excluded from coverage. In accordance with Iowa Code sections 384.6(1) and 411.3, a police chief or fire chief who has submitted a written request to the board of trustees created by section 411.36 to be exempt from chapter 411 is also exempt from coverage under IPERS. The city shall make contributions on behalf of such persons to the international city management association/retirement corporation.

(7) County social welfare employees are included.

(8) Members of county soldiers relief commissions and their administrative or clerical employees are included.

(9) Part-time elected mayors, mayors of townships, and mayors that are paid on a fee basis are covered under IPERS unless they elect out of coverage. All other mayors, including appointed mayors and full-time elected mayors, whether elected by popular vote or by some other means, are covered.

(10) Field assessors are included.

(11) Members of county boards of supervisors who receive an annual salary are included. Effective for terms of office beginning January 1, 1999, and later part-time members of county boards of supervisors who receive an annual salary or are paid on a per diem basis are included unless they elect out of coverage.

(12) Temporary employees of the general assembly who are employed for less than six months in a calendar year or work less than 1,040 hours in a calendar year are included unless the employee elects out of coverage. If coverage is elected, the member may not terminate coverage until termination of covered employment.

(13) Persons hired for temporary employment are excluded from IPERS' coverage providing that they have not established an ongoing relationship with an IPERS-covered employer. Effective January 1, 1993, an ongoing relationship with an IPERS-covered employer is established when the employee is paid covered wages of $300 or more per quarter in two consecutive quarters, or if the employee is employed by a covered employer for 1,040 or more hours in a calendar year. Coverage will begin when the permanency of the relationship is established, and shall continue until the employee's relationship with the covered employer is severed. If there is no formal severance, coverage for a person hired for temporary employment who has established an ongoing relationship with a covered employer will continue until that person completes four consecutive calendar quarters in which no services are performed for that employer after the last covered calendar quarter. Notwithstanding the foregoing sentence, no service credit will be granted to a temporary employee who has become a covered employee under this rule for any calendar quarter in which no covered wages are reported unless the employee is on an approved leave of absence. Contributions shall be paid, and service credit accrued, when wages are paid in the quarter after the ongoing relationship has been established.

(14) Drainage district employees who have vested rights to IPERS through earlier participation or employees of drainage districts are included unless they elect out of coverage.

(15) A county attorney is included as an employee whether or not employed on a full- or part-time basis.

(16) Tax study committee employees are included.

(17) Rescinded IAB 7/22/92, effective 7/2/92.

(18) School bus drivers who are considered to be public employees are included. School bus drivers who are independent contractors are excluded. A determination must be made by IPERS on the facts presented on a case-by-case basis.

(19) Persons who are enrolled as students and whose primary occupations are as students are not covered. Full-time and part-time students who are employed part-time by the institutions where they are enrolled as students are not covered. Full-time and part-time students who are employed full-time or part-time by a covered employer other than the institution where they are enrolled are covered. Full-time employees who are enrolled as part-time students in the institution where they are employed are covered. Full-time and part-time student status is as defined by the individual educational institutions. Full-time and part-time employment status is as defined by the individual employers.

(20) Foreign exchange teachers and visitors including alien scholars, trainees, professors, teachers, research assistants and specialists in their field of specialized knowledge or skill are all excluded from coverage.

(21) Members of any other retirement system in Iowa maintained in whole or part by public funds are excluded. Effective July 1, 1996, an employee who is employed by a covered employer other than the employer that makes contributions on the member's behalf to such other retirement system in Iowa shall be a covered employee, unless the employee receives credit in such other retirement system for both jobs.

(22) Members who are contributing to the federal civil service retirement system or federal employees retirement system are excluded. Effective July 1, 1996, an employee who is employed by a covered employer other than the employer making contributions to such federal retirement systems shall be a covered employee, unless the employee receives credit in such federal retirement systems for both jobs.

(23) Employees of credit unions without capital stock organized and operated for mutual purposes without profit are excluded.

(24) Members of the ministry, rabbinate or other religious order who perform full- or part-time religious service for a covered employer are included; but members of the ministry, rabbinate or other religious order who have taken the vow of poverty are included, unless they elect out of coverage.

(25) Any physician, surgeon, dentist or member of other professional groups employed full-time by a covered employer is included; but any member of a professional group who performs part-time service for any public agency but whose private practice provides the major source of income is excluded, except for city attorneys and health officials.

(26) Interns and resident doctors in the employ of a state or local hospital, school or institution are excluded.

(27) Professional personnel who acquire the status of an officer of the state of Iowa or a political subdivision thereof, even though they engage in private practice and render government service only on a part-time basis, are included.

(28) Effective July 1, 1994, volunteer firefighters and special police officers are considered temporary employees and will be covered if they meet the requirements of 581 IAC 21.5(1)"*a*"(13).

(29) Residents or inmates of county homes are excluded.

(30) Members of the state transportation commission, the board of parole, and the state health facilities council are included unless they elect out of coverage.

(31) Employees of an interstate agency established under Iowa Code chapter 28E, and similar enabling legislation in an adjoining state if the city had made contributions to the system for employees performing functions which are transferred to the interstate agency shall be considered employees of the city for the sole purpose of membership in IPERS, although the employer contributions for those employees are made by the interstate agency.

(32) Persons employed as city managers, or as city administrators performing the duties of city managers, under a form of city government listed in Iowa Code chapter 372 or 420 are included unless they elect out of coverage.

(33) Employees appointed by the state board of regents are covered unless, at the discretion of the state board of regents, they elect coverage in a retirement system qualified by the state board of regents.

(34) School employees who work in additional positions along with normal duties with the same employer will be considered employees until all of their compensated duties to their employer cease. (Examples include teacher/coach; teacher/summer driver's education instructor; and Phase I, II, and III employment.)

(35) "Adjunct instructors" employed by a community college or university are excluded from coverage. Adjunct instructors are persons employed by a community college or university without a continuing contract and whose teaching load does not exceed one-half time for two full semesters or three full quarters for the calendar year. The determination of whether a teaching load exceeds one-half time shall be based on the number of credit hours or noncredit contact hours that the community college or university considers to be a full-time teaching load for a regular full semester or quarter, as the case may be. In determining whether an adjunct instructor is a covered employee, no credit shall be granted for teaching periods of shorter duration than a regular semester or regular quarter (such as summer semesters), regardless of the number of credit or contact hours assigned to that period. If there is no formal severance, an adjunct instructor who becomes a covered employee will remain a covered employee until that person completes four consecutive calendar quarters in which no services are performed for that covered employer after the last covered calendar quarter. Notwithstanding the foregoing sentence, no service credit will be granted to any adjunct instructor who has become a covered employee under this rule for any calendar quarter in which no covered wages are reported unless the adjunct instructor is on an approved leave of absence.

(36) Effective July 1, 1992, enrollees of a senior community service employment program authorized by Title V of the Older Americans Act and funded by the United States Department of Labor are not covered unless: (a) both the enrollee and the covered employer elect coverage; or (b) the enrollee is currently contributing to IPERS. A covered employer is defined as the host agency where the enrollee is placed for training.

(37) Effective July 1, 1994, employees of area agencies on aging are excluded from coverage if the area agency has provided for participation by all of its eligible employees in an alternative qualified plan pursuant to the requirements of the federal Internal Revenue Code. If an area agency on aging does not have or terminates participation in an alternative plan, coverage under IPERS shall begin immediately.

(38) Effective July 1, 1994, arson investigators are no longer covered under IPERS. They were transferred to public safety peace officers' retirement, accident and disability system.

(39) Persons who meet the requirements of independent contractor status as determined by IPERS using the criteria established by the federal Internal Revenue Service are not included.

(40) Effective July 1, 1994, a person employed on or after that date for certain public safety positions is excluded from IPERS coverage. These positions are gaming enforcement officers employed by the division of criminal investigation for excursion boat gambling enforcement activities, fire prevention inspector peace officers, and employees of the division of capitol police (except clerical workers).

(41) Employees of area community colleges are included unless they elect coverage under an alternative system pursuant to a one-time irrevocable election.

(42) Volunteer emergency personnel, such as ambulance drivers, are considered temporary employees and will be covered if they meet the requirements of 581 IAC 21.5(1)*"a"*(13). Persons who meet such requirements will be covered under the protection occupation requirements of Iowa Code section 97B.49(16) if they are considered firefighters by their employers; otherwise they are covered under Iowa Code section 97B.11.

(43) Employees of the Iowa department of public safety hired pursuant to Iowa Code chapter 80 as peace officer candidates are excluded from coverage.

(44) Persons employed through any program described in Iowa Code section 15.225, subsection 1, and provided by the Iowa conservation corps shall not be covered.

(45) Appointed and full-time elective members of boards and commissions who receive a set salary shall be covered. Effective January 1, 1999, part-time elective members of boards and commissions not otherwise described in these rules who receive a set salary are included unless they elect out of coverage. Members of boards, other than county boards of supervisors, and commissions, including appointed and elective full-time and part-time members, who receive only per diem and expenses shall not be covered.

(46) Persons receiving rehabilitation services in a community rehabilitation program, rehabilitation center, sheltered workshop, and similar organizations whose primary purpose is to provide vocational rehabilitation services to target populations shall not be covered.

(47) Persons who are members of a community service program authorized under and funded by grants made pursuant to the federal National and Community Service Act of 1990 shall not be covered.

(48) Persons who are employed by professional employment organizations, temporary staffing agencies, and similar noncovered employers and are leased to covered employers shall be excluded. Notwithstanding the foregoing, persons who are employed by a covered employer and leased to a noncovered employer shall be covered.

(49) Effective July 1, 1999, persons performing referee services for covered employers shall be excluded from coverage, unless the performance of such services is included in the persons' regular job duties for the employers for which such services are performed.

(50) Effective July 1, 2000, patient advocates appointed under Iowa Code section 229.19 shall be included.

b. Each employer shall ascertain the federal social security account number of each employee subject to IPERS.

c. Rescinded IAB 7/5/95, effective 8/9/95.

21.5(2) The employer shall report the employee's federal social security account number in making any report required by IPERS with respect to the employee.

21.5(3) to **21.5(6)** Rescinded IAB 7/22/92, effective 7/2/92.

21.5(7) Effective July 1, 1996, an employee may actively participate in IPERS and another retirement system supported by public funds if the person does not receive credit under both IPERS and such other retirement system for any position held.

This rule is intended to implement Iowa Code sections 97B.1A(8), 97B.42, 97B.42A, 97B.42B, 97B.49C, and 97B.52A and 2000 Iowa Acts, Senate File 2411, section 69.

581—21.6(97B) Wage reporting and payment of contributions by employers.

21.6(1) Any public employing unit whose combined employer/employee IPERS contribution tax equals or exceeds $100 per month is required to pay the tax on a monthly basis. All other employing units are required to file wage reports and pay the contribution tax on a quarterly basis. When IPERS becomes aware of the correct payment and reporting status of an employing unit, IPERS will send to the reporting official a supply of the employer remittance advice forms.

21.6(2) Each periodic wage reporting form must include all employees who earned reportable wages or wage equivalents under IPERS. If an employee has no reportable wage in a quarter but is still employed by the employing unit, the employee should be listed with zero wages.

21.6(3) All checks in payment of the total contribution tax shall be made payable to the Iowa Public Employees' Retirement System and mailed with the employer remittance advice to IPERS, P.O. Box 9117, Des Moines, Iowa 50306-9117.

21.6(4) For employers filing quarterly employer remittance advice forms, contributions must be received by IPERS on or before the fifteenth day of the month following the close of the calendar quarter in which the wages were paid.

For employers filing monthly employer remittance advice forms, contributions must be received by IPERS on or before the fifteenth day of the month following the close of the month in which wages were paid.

Any employer filing monthly or quarterly employer remittance advice forms for two or more entities shall attach to each remittance form the checks covering the contributions due on that form. The combining of contributions due for payment from two or more entities into one check or multiple checks will not be accepted. Improperly paid contributions are considered as unpaid. Upon the request of the employer, IPERS may grant a waiver of the requirement which prohibits the combining of contributions. A single entity which has several accounts will be required to report all wages under one main account effective January 1, 1995.

21.6(5) A request for an extension of time to pay a contribution may be granted by IPERS for good cause if presented before the due date, but no extension shall exceed 30 days after the end of the calendar quarter. If an employer who has been granted an extension fails to pay the contribution on or before the end of the extension period, interest shall be charged and paid from the original due date as if no extension had been granted.

To establish good cause for an extension of time to pay, the employer must show that the failure to pay was not due to mere negligence, lack of ordinary care or attention, carelessness or inattention. The employer must affirmatively show that it did not pay timely because of some occurrence beyond the control of the employer.

21.6(6) When an employer has no reportable wages or no wages to report during the applicable reporting period, the periodic wage reporting document should be marked "no reportable wages" or "no wages" and returned to IPERS. When no employer's wage report is made, the employing unit's account is considered delinquent for the reporting period until the report is filed.

21.6(7) Substitute forms may be used if they meet all the IPERS reporting requirements and the employing unit receives advance approval from IPERS.

21.6(8) Magnetic tape reporting may be used by an employer after submitting a written request to IPERS. When the request is received, IPERS will send the employer a copy of the specifications for this type of reporting.

21.6(9) Contribution rates. The following contribution rate schedule, payable on the covered wage of the member, is determined by the position or classification and the occupation class code of the member.

a. All covered members, except those identified in 21.6(9)*"b"* and *"c."*

(1) Member's rate—3.7%.

(2) Employer's rate—5.75%.

b. Sheriffs, deputy sheriffs, and airport firefighters, effective July 1, 2000.

(1) Member's rate—5.59%.

(2) Employer's rate—8.39%.

c. Members employed in a protection occupation, effective July 1, 2000.

(1) Member's rate—5.90%.

(2) Employer's rate—8.86%.

d. Members employed in a "protection occupation" shall include:

(1) Conservation peace officers.

(2) Effective July 1, 1994, a marshal in a city not covered under Iowa Code chapter 400, or a firefighter or police officer of a city not participating under Iowa Code chapter 410 or 411. (See definitions of employee in subrule 21.5(1).)

Effective January 1, 1995, part-time police officers will be included.

(3) Correctional officers as provided for in Iowa Code section 97B.49B.

Employees who, prior to December 22, 1989, were in a "correctional officer" position but whose position is found to no longer meet this definition on or after that date, shall retain coverage, but only for as long as the employee is in that position or another "correctional officer" position that meets this definition. Movement to a position that does not meet this definition shall cancel "protection occupation" coverage.

(4) Airport firefighters employed by the military division of the department of public defense. Effective July 1, 1994, airport firefighters employed by the military division of the department of public defense shall pay the same contribution rate, and receive benefits under the same formula, as sheriffs and deputy sheriffs. Service under this subrule includes all membership service in IPERS as an airport firefighter.

(5) Airport safety officers employed under Iowa Code chapter 400 by an airport commission in a city of 100,000 population or more, and employees covered by the Iowa Code chapter 19A merit system whose primary duties are providing airport security and who carry or are licensed to carry firearms while performing those duties.

(6) Rescinded IAB 7/5/95, effective 8/9/95.

(7) Effective July 1, 1990, an employee of the state department of transportation who is designated as a "peace officer" by resolution under Iowa Code section 321.477.

(8) Effective July 1, 1992, a fire prevention inspector peace officer employed by the department of public safety. Effective July 1, 1994, a fire prevention inspector peace officer employed before that date who does not elect coverage under Iowa Code chapter 97A in lieu of IPERS.

(9) Effective July 1, 1994, through June 30, 1998, a parole officer III with a judicial district of the department of correctional services.

(10) Effective July 1, 1994, through June 30, 1998, a probation officer III with a judicial district of the department of correctional services.

e. Prior special rates are as follows:

Effective July 1, 1999, through June 30, 2000:

(1) Sheriffs, deputy sheriffs, and airport firefighters—member's rate—5.69%; employer's rate—8.54%.

(2) Protection occupation—member's rate—5.58%; employer's rate—8.38%.

f. Pretax.

(1) Effective January 1, 1995, employers must pay member contributions on a pretax basis for federal income tax purposes only. Such contributions are considered employer contributions for federal income tax purposes and employee contributions for all other purposes. Employers must reduce the member's salary reportable for federal income tax purposes by the amount of the member's contribution.

(2) Salaries reportable for purposes other than federal income tax will not be reduced, including IPERS, FICA, and, through December 31, 1998, state income tax purposes.

(3) Effective January 1, 1999, employers must pay member contributions on a pretax basis as provided in subparagraph (1) above for both federal and state income tax purposes.

21.6(10) Effective July 1, 1992, credit memos that have been issued due to an employer's overpayment are void one year after issuance.

This rule is intended to implement Iowa Code sections 97B.49A to 97B.49I.

581—21.7(97B) Accrual of interest. Interest or charges as provided under Iowa Code section 97B.9 shall accrue on any contributions not received by IPERS by the due date, except that interest or charges may be waived by IPERS upon request prior to the due date by the employing unit, if due to circumstances beyond the control of the employing unit.

This rule is intended to implement Iowa Code section 97B.9 as amended by 2000 Iowa Acts, Senate File 2411, section 22.

581—21.8(97B) Refunds and returns of erroneously paid contributions.

21.8(1) *Refund formula.* A member is eligible for a refund of the employee accumulated contributions 30 days after the member's last paycheck is issued from which IPERS contributions will be deducted. Effective July 1, 1999, a vested member's refund shall also include a portion of the employer accumulated contributions. Refund amounts are determined as follows:

a. Employee accumulated contributions. Upon receiving an eligible member's application for refund, IPERS shall pay to the terminated member the amount of the employee accumulated contributions currently reported to, and processed by, IPERS as of the date of the refund. Upon reconciliation of the final employee contributions for that member, a supplemental refund of the employee accumulated contributions will be paid.

b. Employer accumulated contributions. Effective July 1, 1999, IPERS shall also pay to vested members, in addition to the employee accumulated contributions, a refund of a portion of the employer accumulated contributions. The refundable portion shall be calculated by multiplying the employer accumulated contributions by the "service factor." The "service factor" is a fraction, the numerator of which is the member's quarters of service and the denominator of which is the "applicable quarters." The "applicable quarters" shall be 120 for regular members, 100 for protection occupation members, and 88 for sheriffs, deputy sheriffs and airport firefighters. All quarters of service credit shall be included in the numerator of the service factor. In no event will a member ever receive an amount in excess of 100 percent of the employer accumulated contributions for that member.

In addition to the foregoing provisions, IPERS shall calculate the refundable portion of the employer accumulated contributions as follows:

(1) Upon reconciliation of the final employer contributions for that member, the member's portion of the employer accumulated contributions will be recalculated. IPERS will add the additional quarter(s) of service to the numerator of the service factor. The adjusted service factor will be multiplied by the sum of the original employer accumulated contributions plus the supplemental employer accumulated contributions. The employer accumulated contributions included in the original refund will then be subtracted from that recalculated figure to determine the amount of employer accumulated contributions to be included in the supplemental refund.

(2) The member's portion of employer accumulated contributions shall be determined under subrule 21.8(2) below if the member had a combination of regular service and special service, or a combination of different types of special service.

(3) In making calculations under this subrule and subrule 21.8(2) below, IPERS shall round to not less than six decimal places to the right of the decimal point.

21.8(2) *Refunds for members eligible for a hybrid refund.* Effective July 1, 1999, the calculation of the member's portion of employer accumulated contributions for a "hybrid refund" shall be as follows:

a. A "hybrid refund" is a refund that is calculated for a member who has a combination of regular service and special service quarters, or a combination of different types of special service quarters.

b. If a member is eligible for a hybrid refund, the member's portion of employer accumulated contributions shall be calculated by multiplying the total employer accumulated contributions by: (1) the member's regular service factor, if any; and (2) the protection occupation service factor, if any; and (3) the sheriff/deputy sheriff/airport firefighter service factor, if any (except as otherwise provided in this subrule). The amounts obtained will be added together to determine the amount of the employer accumulated contributions payable. In no event will a member ever receive an amount in excess of 100 percent of the employer accumulated contributions for that member.

c. Upon reconciliation of the final contributions from a member's employer, the member's portion of the employer accumulated contributions under this subrule will be recalculated. IPERS will add the additional quarter(s) of service to the numerator of the applicable service factor. The adjusted service factor will be multiplied by the sum of the original employer accumulated contributions plus the supplemental employer accumulated contributions. The employer accumulated contributions included in the original refund will then be subtracted from that recalculated figure to determine the amount of the employer accumulated contributions to be included in the supplemental refund.

d. If wages reported for a quarter are a combination of regular and special service wages, or different types of special service wages, IPERS will classify the service credit for each quarter based on the largest dollar amount reported for that quarter. A member shall not receive more than one quarter of service credit for any calendar quarter, even though more than one type of service credit is recorded for that quarter.

e. If a member is last employed in a sheriff, deputy sheriff, or airport firefighter position, all quarters of "eligible service," as defined in Iowa Code section 97B.49C(1)"*d,*" shall be counted as quarters of sheriff/deputy sheriff/airport firefighter service credit.

f. A special limitation applies to hybrid refunds where the member and employer contributed at regular rates for quarters that are eligible for coverage under Iowa Code section 97B.49B or Iowa Code section 97B.49C. If a member has regular service credit and special service credit, and any part of the special service credit consists of quarters for which only regular contributions were made, such quarters will be counted as regular service quarters. However, the foregoing limitation will not apply if the member only has service credit eligible for coverage under Iowa Code section 97B.49B, or only has service credit eligible for coverage under Iowa Code section 97B.49C.

g. Except as described above, this subrule shall not be construed to require or permit service eligible for coverage under Iowa Code section 97B.49B to be treated as special service under Iowa Code section 97B.49C, or vice versa, when determining the percentage payable under this subrule.

21.8(3) *Refund of retired reemployed member's contributions.*

a. Less than six months. A retired member who returns to permanent covered employment, but who resigns within six months of the date the reemployment began, is eligible to have the member contributions for this period refunded. The contributions made by the employer will be refunded to the employer.

b. Six months or longer. A retired member who returns to permanent employment and subsequently terminates the member's employment may elect to receive an increased monthly allowance, or a refund of the member's accumulated contributions and, effective July 1, 1998, employer's accumulated contributions accrued during the period of reemployment. A reemployed member who elects a refund under this subrule in lieu of an increased monthly allowance shall forfeit all other rights to benefits under the system with respect to the period of reemployment. If IPERS determines that the reemployment will not increase the amount of a member's monthly benefit, a member shall only elect the refund.

21.8(4) *General administrative provisions.* In addition to the foregoing, IPERS shall administer a member's request for a refund as follows:

a. To obtain a refund, a member must file a refund application form, which is available from IPERS or the member's employer.

b. The last pay date must be certified by the employer on the refund application unless the member has not been paid covered wages for at least one year. The employee's "termination date" is the last date on which the employee was paid and certified by the employer on the IPERS refund application. The applicant's signature must be notarized. Terminated employees must keep IPERS advised in writing of any change in address so that refunds and tax documents may be delivered.

c. Unless otherwise specified by the member, the refund warrant will be mailed to the member at the address listed on the application for refund. If a member so desires, the warrant may be delivered to the member or the member's agent at IPERS' principal office. The member must show verification of identification by presenting a picture identification containing both name and social security number. If a member designates in writing an agent to pick up the refund warrant, the agent must present to IPERS both the written designation and the described picture identification.

d. No payment of any kind shall be made under this rule if the amount due is less than $1.

e. Effective July 1, 2000, an employee is no longer required to be out of covered employment for 30 days before a refund application can be processed. However, an employee must sever all covered employment for four months and cannot file an application after returning to covered employment, even if more than four months have elapsed since the original termination. If the employee returns to covered employment before four months have passed, the refund will be revoked and the amounts paid plus interest must be repaid to the system.

21.8(5) *Emergency refunds.*

a. IPERS may issue an emergency refund to a member who has terminated covered employment and meets the refund eligibility requirements of Iowa Code section 97B.53, if:

(1) The member files an application for refund on a form provided by IPERS;

(2) The member alleges in writing that the member is encountering a financial hardship or unforeseeable emergency; and

(3) The member provides IPERS with payment instructions either in person or in writing.

b. Financial hardship or unforeseeable emergency includes:

(1) Severe financial hardship to a member resulting from a sudden and unexpected illness or accident of the member or a member's dependent;

(2) Loss of a member's property due to casualty; or

(3) Other similar extraordinary and unforeseeable circumstances which arise as a result of events beyond a member's control.

21.8(6) *Erroneously reported wages for employees not covered under IPERS.* Employers who erroneously report wages for employees that are not covered under IPERS may secure a warrant or credit, as elected by the employer, for the employer's contributions by filing an IPERS periodic wage reporting adjustments form available from IPERS. An employer that files a periodic wage reporting adjustments form requesting a warrant or credit shall receive a warrant or credit for both the employer and employee contributions made in error. The employer is responsible for returning the employee's share and for filing corrected federal and state wage reporting forms. Warrants will not be issued by IPERS if the amount due is less than $1. In such cases, the credit will be transferred to the employer's credit memo. Under no circumstance shall the employer adjust these wages by underreporting wages on a future periodic wage reporting document. Wages shall never be reported as a negative amount. An employer that completes the employer portion of an employee's request for a refund on IPERS refund application form will not be permitted to file a periodic wage reporting adjustments form for that employee for the same period of time.

21.8(7) *Contributions paid on wages in excess of the annual covered wage maximum.* Effective for wages paid in calendar years beginning on or after January 1, 1995, IPERS shall automatically issue to each affected employer a warrant or credit, as elected by the employer, of both employer and employee contributions paid on wages in excess of the annual covered wage maximum for a calendar year. A report will be forwarded to each such employer detailing each employee for whom wages were reported in excess of the covered wage ceiling. Warrants or credits for the excess contributions made will be issued to the employers upon IPERS' receipt of certification from said employers that the overpayment report is accurate. Warrants will not be issued if the amount due is less than $1. In such cases, the credit will be transferred to the employer's credit memo. The employer is responsible for returning the employee's share of excess contributions. Where employees have simultaneous employment with two or more employers and as a result contributions are made on wages in excess of the annual covered wage maximum, warrants or credits for the excess employer and employee contributions shall be issued to each employer in proportion to the amount of contributions paid by the employer.

21.8(8) *Termination within less than six months of the date of employment.* If an employee hired for permanent employment resigns within six months of the date of employment, the employer may file IPERS' form for reporting adjustments to receive a warrant or the credit, as elected by the employer, for both the employer's and employee's portion of the contributions. It is the responsibility of the employer to return the employee's share. "Termination within less than six months of the date of employment" means employment is terminated prior to the day before the employee's six-month anniversary date. For example, an employee hired on February 10 whose last day is August 8 would be treated as having resigned within less than six months. An employee hired on February 10 whose last day is August 9 (the day before the six-month anniversary date, August 10) would be treated as having worked six months and would be eligible for a refund.

21.8(9) *Reinstatement following an employment dispute.* If an involuntarily terminated employee is reinstated in covered employment as a remedy for an employment dispute, the member may restore membership service credit for the period covered by the refund by repaying the amount of the refund plus interest within 90 days after the date of the order or agreement requiring reinstatement.

21.8(10) *Commencement of disability benefits under Iowa Code section 97B.50(2).*

a. If a vested member terminates covered employment, takes a refund, and is subsequently approved for disability under the federal Social Security Act or the federal Railroad Retirement Act, the member may reinstate membership service credit for the period covered by the refund by paying the actuarial cost as determined by IPERS' actuary. Repayments must be made by:

(1) For members whose federal social security or railroad retirement disability payments began before July 1, 2000, the repayment must be made within 90 days after July 1, 2000;

(2) For members whose social security or railroad retirement disability payments begin on or after July 1, 2000, the repayment must be made within 90 days after the date federal social security or railroad retirement payments begin; or

(3) For any member who could have reinstated a refund under (1) or (2) above but for the fact that IPERS has not yet received a favorable determination letter from the federal Internal Revenue Service, the repayment must in any event be received within 90 days after IPERS has received such a ruling.

b. IPERS must receive a favorable determination letter from the federal Internal Revenue Service before any refund can be reinstated under this subrule.

This rule is intended to implement Iowa Code sections 97B.10, 97B.46, 97B.50 as amended by 2000 Iowa Acts, Senate File 2411, section 50, and 97B.53 as amended by 2000 Iowa Acts, Senate File 2411, section 63.

581—21.9(97B) Appeals.

21.9(1) *Procedures.*

a. A party who wishes to appeal a decision by IPERS, other than a special service classification or a disability claim under 2000 Iowa Acts, Senate File 2411, section 51, shall, within 30 days after notification was mailed to the party's last-known address, file with IPERS a notice of appeal in writing setting forth:

(1) The name, address, and social security number of the applicant;

(2) A reference to the decision from which the appeal is being made;

(3) The fact that an appeal from the decision is being made; and

(4) The grounds upon which the appeal is based.

Upon receipt of the appeal, IPERS shall conduct an internal review of the facts and circumstances involved, in accordance with its appeal review procedure. IPERS shall issue a final agency decision which becomes final unless within 30 days of issuance the member files a notice of further appeal. Upon receipt of notification of further appeal, IPERS shall inform the department of inspections and appeals of the filing of the appeal and of relevant information pertaining to the case in question. In determining the date that an appeal or any other document is filed with IPERS or the department of inspections and appeals, the following shall apply: An appeal or any other document delivered by mail shall be deemed to be filed on the postmark date; an appeal or any other document delivered by any other means shall be deemed to be filed on the date of receipt. The department of inspections and appeals shall hold a hearing on the case and shall affirm, modify, or reverse the decision by IPERS.

b. Members shall file appeals of their special service classifications with their respective employers, using the appeal procedures of such employers. The appeal procedures for department of corrections employees shall be specified in rules adopted by the personnel division of the Iowa department of personnel. IPERS shall have no jurisdiction over special service classification appeals.

c. Appeals of disability claims under 2000 Iowa Acts, Senate File 2411, section 51, shall be filed and processed as provided under rule 581—21.31(78GA,SF2411).

21.9(2) *The determination of appeals.* Following the conclusion of a hearing of an appeal, the administrative law judge within the department of inspections and appeals shall announce the findings of fact. The decision shall be in writing, signed by the administrative law judge, and filed with IPERS, with a copy mailed to the appellant. Such decision shall be deemed final unless, within 30 days after the issuance date of such decision, further appeal is initiated. The issuance date is the date that the decision is signed by the administrative law judge.

21.9(3) *Appeal board.* A party appealing from a decision of an administrative law judge shall file a notice with the employment appeal board of the Iowa department of inspections and appeals, petitioning the appeal board for review of the administrative law judge's decision. In determining the date that a notice of appeal or any other document is filed with the employment appeal board, and subject to applicable exceptions adopted by the employment appeal board in IAC [486], the following shall apply: an appeal or any other document delivered by mail shall be deemed to be filed as of the postmark date; an appeal or any other document delivered by any other means shall be deemed to be filed as of the date that it is received.

21.9(4) *Judicial review.* The appeal board's decision shall be final and without further review 30 days after the decision is mailed to all interested parties of record unless within 20 days a petition for rehearing is filed with the appeal board or within 30 days a petition for judicial review is filed in the appropriate district court. The department, in its discretion, may also petition the district court for judicial review of questions of law involving any of its decisions. Action brought by the department for judicial review of its decisions shall be brought in the district court of Polk County, Iowa.

21.9(5) *Contested case procedure.* Appeals of decisions by IPERS that are heard by the department of inspections and appeals shall be conducted pursuant to the rules governing contested case hearings adopted by the department of inspections and appeals under 481—Chapter 10.

This rule is intended to implement Iowa Code sections 97B.16, 97B.20, 97B.20A, 97B.20B, 97B.27 and 97B.29 and 2000 Iowa Acts, Senate File 2411, section 51.

581—21.10(97B) Beneficiaries.

21.10(1) Designation of beneficiaries. To designate a beneficiary, the member must complete an IPERS designation of beneficiary form, which must be filed with IPERS. The designation of a beneficiary by a retiring member on the application for monthly benefits is accepted by IPERS in lieu of a completed designation form. IPERS may consider as valid a designation of beneficiary form filed with the member's employer prior to the death of the member, even if that form was not forwarded to IPERS prior to the member's death. If a retired member is reemployed in covered employment, the most recently filed beneficiary form shall govern the payment of all death benefits for all periods of employment. Notwithstanding the foregoing sentence, a reemployed IPERS Option 4 retiree may name someone other than the member's contingent annuitant as beneficiary, but only for death benefits accrued during the period of reemployment and only if the contingent annuitant has died or has been divorced from the member. If a reemployed IPERS Option 4 retiree dies without filing a new beneficiary form, the death benefits accrued for the period of reemployment shall be paid to the member's contingent annuitant, unless the contingent annuitant has died or been divorced from the member. If the contingent annuitant has been divorced from the member, any portion of the death benefits awarded in a qualified domestic relations order (QDRO) shall be paid to the contingent annuitant as alternate payee, and the remainder of the death benefits shall be paid to the member's estate, or the member's heirs if no estate is probated.

21.10(2) Change of beneficiary. The beneficiary may be changed by the member by filing a new designation of beneficiary form with IPERS. The latest dated designation of beneficiary form on file shall determine the identity of the beneficiary. Payment of a refund to a terminated member cancels the designation of beneficiary on file with IPERS.

21.10(3) Payments to a beneficiary. Before death benefit payments can be made, application in writing must be submitted to IPERS with a copy of the member's death certificate, together with information establishing the claimant's right to payment. A named beneficiary must complete IPERS' application for death benefits based on the deceased member's account.

21.10(4) Where the designated beneficiary is an estate, trust, church, charity or other like organization, payment of benefits shall be made in a lump sum only.

21.10(5) Rescinded IAB 7/5/95, effective 8/9/95.

21.10(6) Where multiple beneficiaries have been designated by the member, payment, including the payment of the remainder of a series of guaranteed annuity payments, shall be made in a lump sum only. The lump sum payment shall be paid to the multiple beneficiaries in equal shares unless a different proportion is stipulated.

21.10(7) Payment of the death benefit when no designation of beneficiary or an invalid designation of beneficiary is on file with IPERS shall be made in one of the following ways:

a. Where the estate is open, payment shall be made to the administrator or executor.

b. Where no estate is probated or the estate is closed prior to the filing with IPERS of an application for death benefits, payment will be made to the surviving spouse. The following documents shall be presented as supporting evidence:

(1) Copy of the will, if any;

(2) Copy of any letters of appointment; and

(3) Copy of the court order closing the estate and discharging the executor or administrator.

c. Where no estate is probated or the estate is closed prior to filing with IPERS and there is no surviving spouse, payment will be made to the heirs-at-law as determined by the intestacy laws of the state of Iowa.

d. Where a trustee has been named as designated beneficiary and is not willing to accept the death benefit or otherwise serve as trustee, IPERS may, but is not required to, apply to the applicable district court for an order to distribute the funds to the clerk of court on behalf of the beneficiaries of the member's trust. Upon the issuance of an order and the giving of such notice as the court prescribes, IPERS may deposit the death benefit with the clerk of court for distribution. IPERS shall be discharged from all liability upon deposit with the clerk of court.

21.10(8) Where the member dies prior to the first month of entitlement, the death benefit shall include the accumulated contributions of the member plus the product of an amount equal to the highest year of covered wages of the deceased member and the number of years of membership service divided by the "applicable denominator," as provided in Iowa Code section 97B.52(1). The amount payable shall not be less than the amount that would have been payable on the death of the member on June 30, 1984. The calculation of the highest year of covered wages shall use the highest calendar year of covered wages reported to IPERS.

When a member who has filed an application for retirement benefits and has survived into the first month of entitlement dies prior to the issuance of the first benefit check, IPERS will pay the death benefit allowed under the retirement option elected pursuant to section 97B.48(1) or 97B.51.

21.10(9) Waiver of beneficiary rights. A named beneficiary of a deceased member may waive current and future rights to payments to which the beneficiary would have been entitled. The waiver of the rights shall occur prior to the receipt of a payment from IPERS to the beneficiary. The waiver of rights shall be binding and will be executed on a form provided by IPERS. The waiver of rights may be general, in which case payment shall be divided equally among all remaining designated beneficiaries, or to the member's estate if there are none. The waiver of rights may also expressly be made in favor of one or more of the member's designated beneficiaries or the member's estate. If the waiver of rights operates in favor of the member's estate and no estate is probated or claim made, or if the executor or administrator expressly waives payment to the estate, payment shall be paid to the member's surviving spouse unless there is no surviving spouse or the surviving spouse has waived the surviving spouse's rights. In that case, payment shall be made to the member's heirs excluding any person who waived the right to payment. Any waiver filed by an executor, administrator, or other fiduciary must be accompanied by a release acceptable to IPERS indemnifying IPERS from all liability to beneficiaries, heirs, or other claimants for any waiver executed by an executor, administrator, or other fiduciary.

21.10(10) Payment may be made to a conservator if the beneficiary is under the age of 18 and the total dollar amount to be paid by IPERS to a single beneficiary is $10,000 or more. Payment may be made to a custodian if the total dollar amount to be paid by IPERS to a single beneficiary is less than $10,000.

21.10(11) When a member on benefits returns to covered employment (or remains in covered employment if aged 70 or older), and dies before applying for a recomputation or recalculation of benefits, the death benefit formula will be applied to the wages and years of service reported after benefits begin.

21.10(12) Death benefits shall not exceed the maximum amount possible under the Internal Revenue Code.

21.10(13) IPERS will apply the provisions of the Uniform Simultaneous Death Act, Iowa Code sections 633.523 et seq., in determining the proper beneficiaries of death benefits in applicable cases.

21.10(14) IPERS will apply the provisions of the Felonious Death Act, Iowa Code sections 633.535 et seq., in determining the proper beneficiaries of death benefits in applicable cases.

21.10(15) A completed application must be filed with the department no later than five years after the date of the member's death or the total sum is forfeited. A beneficiary's right to receive a death benefit beyond the five-year limitation shall be extended to the extent permitted under Internal Revenue Code Section 401(a)(9) and the applicable treasury regulations. Notwithstanding the foregoing, the maximum claims period shall not exceed the period required under Internal Revenue Code Section 401(a)(9), which may be less than five years for death benefits payable under benefit options described in Iowa Code sections 97B.49A to 97B.49I and 97B.51(6) and for members who die after their required beginning date. The claims period for all cases in which the member's death occurs during the same calendar year in which a claim must be filed under this subrule shall end April 1 of the year following the year of the member's death.

21.10(16) Effective July 1, 1998, a member's beneficiary or heir may file a claim for previously forfeited death benefits. Interest for periods prior to the date of the claim will only be credited through the quarter that the death benefit was required to be forfeited by law. For claims filed prior to July 1, 1998, interest for the period following the quarter of forfeiture will accrue beginning with the third quarter of 1998. For claims filed on or after July 1, 1998, interest for the period following the quarter of forfeiture will accrue beginning with the quarter that the claim is received by IPERS. For death benefits required to be forfeited in order to satisfy Section 401(a)(9) of the federal Internal Revenue Code, in no event will the forfeiture date precede January 1, 1988. IPERS shall not be liable for any excise taxes imposed by the Internal Revenue Service on reinstated death benefits.

21.10(17) Interest is only accrued if the member dies before the member's retirement first month of entitlement (FME) or, for a retired reemployed member, before the member's reemployment FME, and is only accrued with respect to the retired or retired reemployed member's accumulated contributions account.

21.10(18) Death benefits under Iowa Code section 97B.52(1)*"b."*

a. The death benefit provided for under Iowa Code section 97B.52(1) is intended to benefit beneficiaries of members who die before retiring and shall not apply to retired reemployed members. For retired reemployed members who die during the period of reemployment, the member's death benefits shall be provided under the option elected at retirement subject to adjustments for reemployment wages.

b. An "eligible beneficiary" is one who receives preretirement death benefits during the period January 1, 1999, through December 31, 2000, (or if later, the date the system's actuary approves the payment of benefits under Iowa Code section 97B.52(1) as amended by 2000 Iowa Acts, Senate File 2411, section 75) and may elect to receive the larger of the lump sum amounts available under Iowa Code section 97B.52(1) or to receive a single life annuity that is the actuarial equivalent of the larger of such lump sum amounts. The eligible beneficiary must repay the prior death benefit received as follows:

(1) If the eligible beneficiary wishes to receive the larger lump sum amount, if any, the system shall pay the difference between the prior death benefit lump sum amount and the new death benefit lump sum amount to the eligible beneficiary or as directed by the eligible beneficiary in writing.

(2) If the eligible beneficiary wishes to receive a single life annuity under Iowa Code section 97B.52(1) as amended by 2000 Iowa Acts, Senate File 2411, section 75, the eligible beneficiary may either:

1. Annuitize the difference between the previously paid lump sum amount and the new larger lump sum amount, if any; or

2. Annuitize the full amount of the largest of the lump sum amounts available under Iowa Code section 97B.52(1) as amended by 2000 Iowa Acts, Senate File 2411, section 75, but conditioned upon repaying the full amount of the previously paid lump sum amount.

(3) To the extent possible, repayment costs shall be recovered from retroactive monthly payments, if such retroactive monthly payments are authorized by statute or rule, and the balance shall be offset against current and future monthly payments until the system is repaid in full.

c. Claims for a single life annuity under this subrule filed by eligible beneficiaries and beneficiaries of members who die on or after the implementation date must be filed as follows:

(1) An eligible beneficiary must file a claim for a single life annuity within 12 months of the implementation date.

(2) The beneficiary of a member who dies while actively employed on or after the implementation date must file a claim for a single life annuity within 12 months of the member's death, provided that a surviving spouse must file a claim for a single life annuity by the date that the member would have attained the age of 70½.

d. Elections to receive the lump sum amounts or single life annuity available under Iowa Code section 97B.52(1) as amended by 2000 Iowa Acts, Senate File 2411, sections 53 and 75, and this subrule shall be irrevocable once the first payment is made.

This rule is intended to implement Iowa Code sections 97B.1A(8), 97B.1A(17), 97B.34, 97B.34A, 97B.44 and 97B.52 as amended by 2000 Iowa Acts, Senate File 2411, sections 53 and 75.

581—21.11(97B) Application for benefits.

21.11(1) Form used. It is the responsibility of the member to notify IPERS of the intention to retire. This should be done 60 days before the expected retirement date. The application for monthly retirement benefits is obtainable from IPERS, 600 East Court Avenue, P.O. Box 9117, Des Moines, Iowa 50306-9117. The printed application form shall be completed by each member applying for benefits and shall be mailed or brought in person to IPERS. Option choice and date of retirement shall be clearly stated on the application form and all questions on the form shall be answered in full. If an optional allowance is chosen by the member in accordance with Iowa Code section 97B.48(1) or 97B.51, the election becomes binding when the first retirement allowance is paid. A retirement application is deemed to be valid and binding when the first payment is paid. Members may not cancel their applications, change their option choice, or change an Option 4 contingent annuitant after that date.

21.11(2) Proof required in connection with application. Proof of date of birth to be submitted with an application for benefits shall be in the form of a birth certificate or an infant baptismal certificate. If these records do not exist, the applicant shall submit two other documents or records which will verify the day, month and year of birth. A photographic identification record may be accepted even if now expired unless the passage of time has made it impossible to determine if the photographic identification record is that of the applicant. The following records or documents are among those deemed acceptable to IPERS as proof of date of birth:

a. United States census record;

b. Military record or identification card;

c. Naturalization record;

d. A marriage license showing age of applicant in years, months and days on date of issuance;

e. A life insurance policy;

f. Records in a school's administrative office;

g. An official form from the United States Immigration Service, such as the "green card," containing such information;

h. Driver's license or Iowa nondriver identification card;

i. Adoption papers;

j. A family Bible record. A photostatic copy will be accepted with certification by a notary that the record appears to be genuine; or

k. Any other document or record ten or more years old, or certification from the custodian of such records which verifies the day, month, and year of birth.

Under subrule 21.11(6), IPERS is required to begin making payments to a member or beneficiary who has reached the required beginning date specified by Internal Revenue Code Section 401(a)(9). In order to begin making such payments and to protect IPERS' status as a plan qualified under Internal Revenue Code Section 401(a), IPERS may rely on its internal records with regard to date of birth, if the member or beneficiary is unable or unwilling to provide the proofs required by this subrule within 30 days after written notification of IPERS' intent to begin mandatory payments.

21.11(3) Retirement benefits and the age reduction factor.

a. A member shall be eligible for monthly retirement benefits with no age reduction effective with the first of the month in which the member becomes the age of 65, if otherwise eligible.

b. Effective July 1, 1998, a member shall be eligible for full monthly retirement benefits with no age reduction effective with the first of the month in which the member becomes the age of 62, if the member has 20 full years of service and is otherwise eligible.

c. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55.

These benefits are computed in accordance with Iowa Code sections 97B.49A to 97B.49I.

21.11(4) A member shall be eligible to receive monthly retirement benefits effective with the first day of the month in which the member becomes the age of 70, even though the member continues to be employed.

21.11(5) A member shall be eligible to receive benefits for early retirement effective with the first of the month in which the member attains the age of 55 or the first of any month after attaining the age of 55 before the member's normal retirement date, provided the date is after the last day of service.

21.11(6) A member retiring on or after the early retirement or normal retirement date shall submit a written notice to IPERS setting forth the retirement date, provided the date is after the member's last day of service. A member's first month of entitlement shall be no earlier than the first day of the first month after the member's last day of service or, if later, the month provided for under subrule 21.18(2). A member who does not begin benefits timely in the first month that begins after the member's last day of service may receive up to six months of retroactive payments. The period for which retroactive payments may be paid is measured from the month that a valid contact occurs. For purposes of this subrule, a "contact" means a telephone call, facsimile transmission, E-mail, visit to IPERS at its offices or offsite locations, or a letter or other writing requesting a benefits estimate or application to retire, whichever is received first. A contact is only valid if a completed application to retire is received within six months following the month that a benefits estimate or application to retire form is mailed to the member in response to the contact. If a completed application to retire form is received more than six months after such a benefits estimate or application to retire is mailed, retroactive payments may only be made for up to six months preceding the month that the completed application to retire is received.

Notwithstanding the foregoing, IPERS shall commence payment of a member's retirement benefit under Iowa Code sections 97B.49A to 97B.49I (under Option 2) no later than the "required beginning date" specified under Internal Revenue Code Section 401(a)(9), even if the member has not submitted the appropriate notice. If the lump sum actuarial equivalent could have been elected by the member, payments shall be made in such a lump sum rather than as a monthly allowance. The "required beginning date" is defined as the later of: (1) April 1 of the year following the year that the member attains the age of 70½, or (2) April 1 of the year following the year that the member actually terminates all employment with employers covered under Iowa Code chapter 97B.

If IPERS distributes a member's benefits without the member's consent in order to begin benefits on or before the required beginning date, the member may elect to receive benefits under an option other than the default option described above, or as a refund, if the member contacts IPERS in writing within 60 days of the first mandatory distribution. IPERS shall inform the member what adjustments or repayments are required in order to make the change.

If a member cannot be located so as to commence payment on or before the required beginning date described above, the member's benefit shall be forfeited. However, if a member later contacts IPERS, and wishes to file an application for retirement benefits, the member's benefits shall be reinstated. A member whose benefits are forfeited and then reinstated under this subrule shall only qualify for retroactive payments to the extent provided under Iowa Code section 97B.48(2).

21.11(7) Retirement benefits to a member shall terminate the day on which the member's death occurs. The benefits for the month of the member's death shall be prorated based on the number of days the member lived during that month. Notwithstanding the foregoing, for each death occurring on or after July 1, 1998, a member's retirement benefits shall terminate after payment is made to the member for the entire month during which the member's death occurs. For such deaths, death benefits shall begin with the month following the month in which the member's death occurs.

21.11(8) Upon the death of the retired member, IPERS will reconcile the decedent's account to determine if an overpayment was made to the retiree and if a further payment(s) is due to the retired member's named beneficiary, contingent annuitant, heirs-at-law or estate. If an overpayment has been made to the retired member, IPERS will determine if steps should be taken to seek collection of the overpayment from the named beneficiary, contingent annuitant, estate, heirs-at-law, or other interested parties.

The waiver of the necessary steps to effect collection may occur in cases where recovery of the moneys is not probable and where that action is not deemed prudent administration or cost-effective utilization of the funds of the system.

21.11(9) To receive retirement benefits, a member under the age of 70 must officially leave employment with an IPERS covered employer, give up all rights as an employee, and complete a period of bona fide retirement. A period of bona fide retirement means four or more consecutive calendar months for which the member qualifies for monthly retirement benefit payments. The qualification period begins with the member's first month of entitlement for retirement benefits as approved by IPERS. A member may not return to covered employment before filing a completed application for benefits.

A member will not be considered to have a bona fide retirement if the member is a school or university employee and returns to work with the employer after the normal summer vacation. In other positions, temporary or seasonal interruption of service which does not terminate the period of employment does not constitute a bona fide retirement. A member also will not be considered to have a bona fide retirement if the member has, prior to the member's first month of entitlement, entered into contractual arrangements with the employer to return to employment after the expiration of the four-month bona fide retirement period.

Effective July 1, 1990, a school employee will not be considered terminated if, while performing the normal duties, the employee performs for the same employer additional duties which take the employee beyond the expected termination date for the normal duties. Only when all the employee's compensated duties cease for that employer will that employee be considered terminated.

The bona fide retirement period will be waived, however, if the member is elected to public office which term begins during the normal four-month bona fide retirement period. This waiver does not apply if the member was an elected official who was reelected to the same position for another term. The bona fide retirement period will also be waived for state legislators who terminate their nonlegislative employment and the IPERS coverage for their legislative employment and begin retirement but wish to continue with their legislative duties.

A member will have a bona fide retirement if the member returns to work as an independent contractor with a public employer during the four-month qualifying period. Independent contractors are not covered under IPERS.

Effective July 1, 1998, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered by this chapter, with such employer is terminated and the member receives at least four monthly benefit payments. In order to receive retirement benefits, the member must file a completed application for benefits form with the department before returning to any employment with the same employer.

Notwithstanding the foregoing, the continuation of group insurance coverage at employee rates for the remainder of the school year for a school employee who retires following completion of services by that individual shall not cause that person to be in violation of IPERS' bona fide retirement requirements.

Effective July 1, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered under this chapter, is terminated for at least one month, and the member does not return to covered employment for an additional three months. In order to receive retirement benefits, the member must file a completed application for benefits form with the department before returning to any employment with a covered employer.

21.11(10) If a member files a retirement application but fails to select a first month of entitlement, IPERS will select by default the earliest month possible. A member may appeal this default selection by sending written notice of the appeal postmarked on or before 30 days after a notice of the default selection was mailed to the member. Notice of the default selection is deemed sufficient if sent to the member at the member's address of record.

This rule is intended to implement Iowa Code sections 97B.5, 97B.15, 97B.48(1), 97B.49A to 97B.49I, 97B.50(1), 97B.51, 97B.52, and 97B.52A as amended by 2000 Iowa Acts, Senate File 2411, sections 59 and 60.

581—21.12(97B) Service credit. An employee working in a position for a school district or other institution which operates on a nine-month basis shall be credited with a year of service for each year in which three quarters of coverage are recorded, if the employee returns to covered employment the next operating year. The foregoing sentence shall be implemented as follows. A member will receive credit for the third quarter when no wages are reported in that quarter if the member works the following three calendar quarters and had covered wages or was on an approved leave of absence in the immediately preceding second quarter. An individual employed on a fiscal- or calendar-year basis shall be credited with a year of service for each year in which four quarters of coverage are recorded.

21.12(1) *Prior service.*

a. A member shall receive prior service credit if the member made contributions under the abolished Iowa Old-Age and Survivors' Insurance (IOASI) System and has not qualified for IOASI benefits. If qualified, a member will be granted credit for verified service that occurred during and prior to the IOASI period.

b. Effective July 1, 1990, "public employee" means not only an employee who had made contributions under IOASI, but also includes a member who had service as a public employee prior to July 4, 1953, in another state, or for the federal government, or within other retirement systems established in the state of Iowa and who qualifies for the buy-in programs referenced in 21.24(2). To receive credit for service in another system, however, the public employee who had not made contributions to IOASI but who wishes to receive prior service credit for public employment elsewhere must meet the following conditions:

(1) Have been a public employee;

(2) Waive on a form provided by IPERS all rights to a retirement in another system for that period of employment for the public employer(s), if any; and

(3) Submit verification of service for that other public employer to IPERS.

A qualifying member who decides to purchase IPERS credit for prior service must make employer and employee contributions to IPERS for each year of service or fraction thereof allowed in this buy-in. This contribution shall be equal to the member's covered IPERS wages for the most recent full calendar year of IPERS coverage, using the rates in Iowa Code sections 97B.11, 97B.49B and 97B.49C then applicable to the type of service credit being purchased, and multiplied by the number of years or fraction thereof being purchased from other public employment.

c. Prior to July 1, 1990, public employment must have been for the state of Iowa, or a county, city, township, school district of the state of Iowa, or a political subdivision, provided the employment was not in an elective position, and provided further that the employee is not covered by another retirement plan funded in whole or in part by the state of Iowa or a political subdivision. Effective July 1, 1990, public employment may also include service for a public employer in another state, for the federal government, or for public employment covered by another retirement system within the state of Iowa.

d. For the purposes of this rule, public school teachers are considered to have been in service on July 4, 1953, if they were under contract at the end of the school year 1952-1953 or if they signed a contract for the 1953-1954 school year on or before July 4, 1953.

21.12(2) *Prior service credit for vacation or leave of absence.*

a. Prior service credit shall be given for a period of vacation or leave of absence authorized by the employer not to exceed 12 months. If a period of vacation or leave of absence exceeds 12 months, prior service credit shall be given for the first 12 months only. However, if a period of vacation or leave of absence was granted for 12 months or less, and renewed for 12 months or less, all periods of vacation or leave of absence shall be included as prior service, even though all periods added together exceed 12 months.

b. Reentry into public employment by an employee on leave of absence can be achieved by the employee by accepting employment with any public employer, provided there is no interruption between the end of the period of the leave of absence and reentry into public employment.

c. The employer must verify the inclusive dates of the period of vacation or leave of absence before prior service can be given.

21.12(3) *Prior service credit for military service.*

a. Prior service credit shall be given for the entire period of military service during a war or national emergency, provided the employee was employed by the employer immediately prior to entry into military service and the employee returned to work for the same employer within 12 months after release from service.

b. The employer must verify the inclusive dates of the period of absence from work. A copy of the enlistment and discharge records must also be provided to IPERS to verify enlistment and discharge dates.

21.12(4) *Prior service credit for interruption in service.* Prior service credit shall be given for periods of temporary or seasonal interruption in service where the temporary suspension of service does not terminate the period of employment of the employee. Verification from the employer is needed stating the dates of employment, periods of interruption and that employment was not terminated during those periods.

21.12(5) *Prior service credit for part-time employment.*

a. Effective July 1, 1990, if a member had covered wages reported in any quarter or the custodian of the record certifies service in any quarter, a full quarter of credit will be granted.

b. A teacher will receive credit for a full year in which three quarters of coverage are reported or three quarters of service are certified by the custodian of the records if the teacher had a contract for the following school year. IPERS may require the submission of a copy of that contract.

c. Prior to July 1, 1990, prior service credit for part-time employment was granted on the basis of actual time worked. A ratio determined either by dividing the actual average time worked per day by the normal full-time day or by some other reasonable method was used to calculate the actual time worked.

21.12(6) *Prior service credit for a set period of time.*

a. Effective July 1, 1990, prior service credit will be granted for those quarters in which covered wages were reported or if the custodian of the record certifies service.

b. Prior to July 1, 1990, full prior service credit was given for periods of employment which required the employee to be available for as much work as required, even though the employee may not have actually worked full-time. This includes the employment of town clerks, secretaries of school districts, school bus drivers and school lunch employees.

21.12(7) *Prior service credit for school year.* A public school teacher who worked full-time the entire school year shall be given a full year of prior service credit.

a. Effective July 1, 1990, if a member had covered wages reported in any quarter or the custodian of the record certifies service in any quarter, a full quarter of credit will be granted.

A teacher will receive credit for a full year in which three quarters of coverage are reported or three quarters of service are certified by the custodian of the records if the teacher had a contract for the following school year. IPERS may require the submission of a copy of that contract.

b. Prior to July 1, 1990, school employees may have received less than a full year's credit if they had reportable wages in fewer than four quarters.

21.12(8) *Proof of prior service.*

a. A statement showing the inclusive dates of employment and the position(s) the member held shall be signed by the present custodian of those employment records. IPERS Form 507 or a statement containing similar information may be used for this purpose. This statement does not require notarization.

b. If an employment record is not available for any reason, notarized affidavits of two individuals having knowledge of the employment for which prior service credit is sought shall be submitted. IPERS Form 507-A or an affidavit containing similar information may be used.

c. Proof of prior service will be scrutinized to ensure that:

(1) It refers to covered employment in Iowa;

(2) It is signed by the proper authority;

(3) It refers to the member in question;

(4) The position held is one for which prior service credit can be given;

(5) Any corrections, deletions, or additions in dates of service are initialed by the signer of the document;

(6) Anything on the reverse side of the form is taken into consideration; and

(7) Certification showing the highest gross wage earned in any 12 consecutive month period before July 4, 1953, refers to a period ending before that date. IOASI records may be used for verification of wages if necessary, and this information is noted on the face of IPERS Form 502, application for monthly retirement allowance.

d. Effective July 1, 1990, prior service will be credited by quarters. Service of less than a full quarter shall be rounded up to a full quarter. (Prior to July 1, 1990, the amount of prior service credit due on each proof of service was computed in years, months and days.)

e. If the custodian of the records cannot verify service before July 4, 1953, or if the member disputes the amount of time proven, IPERS may use any records available to supplement the member's proof.

21.12(9) *Prior service credit for service before January 1, 1946.* An active, vested or retired member who was employed prior to January 1, 1946, by an employer may file written verification of the member's dates of employment with IPERS and receive credit for years of prior service for the period of employment. However, a member who is eligible for or receiving a pension or annuity from a local school district for service prior to January 1, 1946, is not eligible to receive credit for the period of service upon which the pension or annuity is based. The member is responsible to obtain sufficient proof of service prior to January 1, 1946, as IPERS may require.

21.12(10) *Membership service.* A member shall receive membership service credit for service rendered after July 4, 1953. Service is counted to the complete quarter calendar year. A calendar year shall not include more than four quarters.

This rule is intended to implement Iowa Code sections 97B.41(12), 97B.43 and 97B.75.

581—21.13(97B) Calculation of monthly retirement benefits.

21.13(1) If a member has four or more complete years of service credit in IPERS, a monthly payment allowance will be paid beginning with the first full month after all employment with all covered employers terminates. This allowance will be paid in accordance with the applicable paragraph of this rule and any option the member may elect pursuant to Iowa Code section 97B.51. IPERS shall determine on the applicable forms which designated fractions of a member's monthly retirement allowance payable to contingent annuitants shall be provided as options under Iowa Code section 97B.51(1). Any option elected by a member under Iowa Code section 97B.51 must comply with the requirements of the Internal Revenue Code that apply to governmental pension plans, including but not limited to Internal Revenue Code Section 401(a)(9). If a member has less than four complete years of service credit, the benefit receivable will be computed on a money purchase basis, with reference to annuity tables used by IPERS in accordance with the member's age. Benefits are not payable before the age of 55, except after July 1, 1990, in accordance with an early distribution in the case of retirement due to disability, as described in rule 581—21.22(97B).

21.13(2) Reduction for early retirement.

a. Effective July 1, 1988, a member's benefit formula will be reduced by one-quarter of 1 percent for each month the member's retirement precedes the normal retirement date, as defined in Iowa Code section 97B.45 excluding section 97B.45(4). The following are situations in which a member is considered to be taking early retirement:

(1) If a member is less than the age of 65 in the member's first month of entitlement and has less than 20 years of service; or

(2) If a member is less than 62 years of age in the month of the member's retirement and has 20 years of service.

b. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55.

c. Effective July 1, 1991, a member qualifying for early retirement due to disability under Iowa Code section 97B.50 shall not be subject to a reduction in benefits due to age.

d. If a member retires with at least 20 years of service but is less than the age of 62, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the month in which the member attains the age of 62. If a member retires with less than 20 years of service, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the month in which the member attains the age of 65.

e. Effective January 1, 2001, or such later date that the actuary certifies that the change can be made without increasing contributions, the age reduction shall be calculated by deducting 0.25 percent per month for each month that the first month of entitlement precedes the earliest possible normal retirement date for that member based on the age and years of service at the member's actual retirement.

21.13(3) A member's early retirement date shall be the first day of the month of the fifty-fifth birthday or any following month before the normal retirement date, provided that date is after the last day of service.

21.13(4) Members employed before January 1, 1976, and retiring after January 1, 1976, with four or more complete years of membership service shall be eligible to receive the larger of a monthly formula benefit equal to the member's total covered wages multiplied by one-twelfth of one and fifty-seven hundredths percent, multiplied by the percentage calculated in subrule 21.13(2), if applicable, or a benefit as calculated in subrule 21.13(6).

21.13(5) Members employed before January 1, 1976, who qualified for prior service credit shall be eligible to receive a monthly formula benefit of eight-tenths of one percent multiplied by each year of prior service multiplied by the monthly rate of the member's total remuneration during the 12 consecutive months of prior service for which the total remuneration was the highest, disregarding any monthly rate amount in excess of $250, plus three-tenths of one percent of the monthly rate amount not in excess of $250 for each year in which accrued liability for benefit payments created by the abolished system is funded.

21.13(6) Benefit formula.

a. For each active member retiring on or after July 1, 1994, with four or more complete years of service, the monthly benefit will be equal to one-twelfth of an amount equal to 60 percent of the three-year average covered wage multiplied by a fraction of years of service.

b. For all active and inactive vested members, the monthly retirement allowance shall be determined on the basis of the formula in effect on the date of the member's retirement. If the member takes early retirement, the benefit shall be adjusted as provided in subrule 21.13(2).

c. Effective July 1, 1996, in addition to the 60 percent multiplier identified above, members who retire with years of service in excess of their "applicable years" shall have the percentage multiplier increased by 1 percent for each year in excess of their "applicable years," not to exceed an increase of 5 percent. For regular members, "applicable years" means 30 years; for protection occupation members, "applicable years" means 25 years; for sheriffs, deputy sheriffs, and airport firefighters, "applicable years" means 22 years. Effective July 1, 1998, sheriffs, deputy sheriffs, and airport firefighters who retire with years of service in excess of their applicable years shall have their percentage multiplier increased by 1.5 percent for each year in excess of their applicable years, not to exceed an increase of 12 percent.

Notwithstanding the provisions of the foregoing paragraph, effective July 1, 2000, the "applicable years" and increases in the percentage multiplier for years in excess of the applicable years for protection occupation members shall be determined under Iowa Code section 97B.49B(1) as amended by 2000 Iowa Acts, Senate File 2411, sections 36 and 37.

d. For special service members covered under Iowa Code section 97B.49B as amended by 2000 Iowa Acts, Senate File 2411, sections 36 and 37, the applicable percentage and applicable years for members retiring on or after July 1, 2000, shall be determined as follows:

(1) For each member retiring on or after July 1, 2000, and before July 1, 2001, 60 percent plus, if applicable, an additional 0.25 percent for each additional quarter of eligible service beyond 24 years of service (the "applicable years"), not to exceed 6 additional percentage points;

(2) For each member retiring on or after July 1, 2001, and before July 1, 2002, 60 percent plus, if applicable, 0.25 percent for each additional quarter of eligible service beyond 23 years of service (the "applicable years"), not to exceed a total of 7 additional percentage points;

(3) For each member retiring on or after July 1, 2002, and before July 1, 2003, 60 percent plus, if applicable, 0.25 percent for each additional quarter of eligible service beyond 22 years of service (the "applicable years"), not to exceed a total of 8 additional percentage points;

(4) For each member retiring on or after July 1, 2003, 60 percent plus, if applicable, an additional 0.25 percent for each additional quarter of eligible service beyond 22 years of service (the "applicable years"), not to exceed a total of 12 additional percentage points.

Regular service does not count as "eligible service" in determining a special service member's applicable percentage.

21.13(7) Average covered wages.

a. "Three-year average covered wage" means a member's covered calendar year wages averaged for the highest three years of the member's service. However, if a member's final quarter of a year of employment does not occur at the end of a calendar year, IPERS may determine the wages for the third year by computing the final quarter or quarters of wages to complete the year. The computed year wages shall not exceed the maximum covered wage in effect for that calendar year. Furthermore, for members whose first month of entitlement is January of 1999 or later, the computed year shall not exceed the member's highest actual calendar year of covered wages by more than 3 percent.

For members whose first month of entitlement is January 1995 or later, a full third year will be created when the final quarter or quarters reported are combined with a computed average quarter to complete the last year. The value of this average quarter will be computed by selecting the highest covered wage-year not used in the computation of the three high years and dividing the covered salary by four quarters. This value will be combined with the final quarter or quarters to complete a full calendar year. If the member's final quarter of wages will reduce the three-year average covered wage, it can be dropped from the computation. However, if the covered wages for that quarter are dropped, the service credit for that quarter will be forfeited as well. If the final quarter is the first quarter of a calendar year, those wages must be used in order to give the member a computed year. The three-year average covered wage cannot exceed the highest maximum covered wages in effect during the member's service.

If the three-year average covered wage of a member who retires on or after January 1, 1997, and before January 1, 2002, exceeds the limits set forth in paragraph *"b"* below, the longer period specified in paragraph *"b"* shall be substituted for the three-year averaging period described above. No quarters from the longer averaging period described in paragraph *"b"* shall be combined with the final quarter or quarters to complete the last year.

b. For the persons retiring during the period beginning January 1, 1997, and ending December 31, 2001, the three-year average covered wage shall be computed as follows:

(1) For a member who retires during the calendar year beginning January 1, 1997, and whose three-year average covered wage at the time of retirement exceeds $48,000, the member's covered wages averaged for the highest four years of the member's service or $48,000, whichever is greater.

(2) For a member who retires during the calendar year beginning January 1, 1998, and whose three-year average covered wage at the time of retirement exceeds $52,000, the member's covered wages averaged for the highest five years of the member's service or $52,000, whichever is greater.

(3) For a member who retires during the calendar year beginning January 1, 1999, and whose three-year average covered wage at the time of retirement exceeds $55,000, the member's covered wages averaged for the highest six years of the member's service or $55,000, whichever is greater.

(4) For a member who retires on or after January 1, 2000, but before January 1, 2001, and whose three-year average covered wage at the time of retirement exceeds $65,000, the member's covered wages averaged for the highest six years of the member's service or $65,000, whichever is greater. For the calendar year beginning January 1, 2001, the six-year wage averaging trigger shall be increased to $75,000.

For purposes of this paragraph *"b,"* the highest years of the member's service shall be determined using calendar years and may be determined using one computed year. The computed year shall be calculated in the manner and subject to the restrictions provided in paragraph *"a."*

21.13(8) Initial benefit determination.

a. The initial monthly benefit for the retiree will be calculated utilizing the highest three calendar years of wages that have been reported as of the member's retirement. When the final quarter(s) of wages is reported for the retired member, a recalculation of benefits will be performed by IPERS to determine if the "computed year" as described in Iowa Code section 97B.1A(23) and 581 IAC 21.13(7), or the final calendar year, is to be used in lieu of the lowest of the three calendar years initially selected. In cases where the recalculation determines that the benefit will be changed, the adjustment in benefits will be made retroactive to the first month of entitlement. The wages for the "computed year" shall not exceed the highest covered wage ceiling in effect during the member's period of employment.

b. In cases where the member's final quarter's wages have been reported to IPERS prior to retirement, the original benefit will be calculated utilizing all available wages.

c. The option one death benefit amount cannot exceed the member's investment and cannot lower the member's benefit below the minimum distribution required by federal law.

21.13(9) Minimum benefits. Effective January 1, 1997, those members and beneficiaries of members who retired prior to July 1, 1990, and who upon retirement had years of service equal to or greater than 10, will receive a minimum benefit as follows:

a. The minimum benefit is $200 per month for those members with 10 years of service who retired under Option 2. The minimum shall increase by $10 per year or $2.50 per each additional quarter of service to a maximum benefit of $400 per month for members with 30 years of service. No increase is payable for years in excess of 30. The minimum benefit will be adjusted by a percentage that reflects option choices other than Option 2, and a percentage that reflects any applicable early retirement penalty.

b. In determining minimum benefits under this rule, IPERS shall use only the years of service the member had at first month of entitlement (FME). Reemployment periods and service purchases completed after FME shall not be used to determine eligibility.

c. The adjusted minimum benefit amount shall be determined using the option and early retirement adjustment factors set forth below.

1. The option adjustment factor is determined as follows:

Option 1	.94
Option 2	1.00
Option 3	1.00
Option 4 (100%)	.87
Option 4 (50%)	.93
Option 4 (25%)	.97
Option 5	.97

2. The early retirement adjustment factor is determined as follows:

There is no early retirement adjustment if the member's age at first month of entitlement equals or exceeds 65, or if the member's age at first month of entitlement is at least 62 and the member had 30 or more years of service.

The early retirement adjustment for members having 30 years of service whose first month of entitlement occurred before the member attained age 62 is .25 percent per month for each month the first month of entitlement precedes the member's sixty-second birthday.

The early retirement adjustment for members having less than 30 years of service whose first month of entitlement occurred before the member attained age 65 is .25 percent per month for each month the first month of entitlement precedes the member's sixty-fifth birthday.

IPERS shall calculate the early retirement adjustment factor to be used in paragraph *"d"* below as follows: 100% - (minus) early retirement adjustment percentage = early retirement adjustment factor.

The early retirement adjustment shall not be applied to situations in which the member's retirement was due to a disability that qualifies under Iowa Code section 97B.50.

d. IPERS shall use the following formula to calculate the adjusted minimum benefit: unadjusted minimum benefit x (times) option adjustment factor × (times) early retirement adjustment factor = adjusted minimum benefit.

e. IPERS shall compare the member's current benefit to the adjusted benefit determined as provided above. If the member's current benefit is greater than or equal to the adjusted minimum benefit, no change shall be made. Otherwise, the member shall receive the adjusted minimum benefit.

f. Effective January 1, 1999, the monthly allowance of certain retired members and their beneficiaries, including those whose monthly allowance was increased by the operation of paragraphs *"a"* to *"e"* above, shall be increased. If the member retired from the system before July 1, 1986, the monthly allowance currently being received by the member or the member's beneficiary shall be increased by 15 percent. If the member retired from the system on or after July 1, 1986, and before July 1, 1990, the monthly allowance currently being received by the member or the member's beneficiary shall be increased by 7 percent.

21.13(10) Hybrid formula for members with more than one type of service credit.

a. Eligibility. Effective July 1, 1996, members having both regular and special service credit (as defined in Iowa Code section 97B.1A(21)) shall receive the greater of the benefit amount calculated under this subrule, or the benefit amount calculated under the applicable nonhybrid benefit formula.

(1) Members who have a combined total of 16 quarters of service may utilize the hybrid formula.

(2) Members who have both types of special service under Iowa Code section 97B.1A(21), but do not have any regular service, may utilize the hybrid formula.

(3) The following classes of members are not eligible for the hybrid formula:

1. Members who have only regular service credit.

2. Members who have 22 years of sheriff/deputy sheriff/airport firefighter service credit as defined under Iowa Code section 97B.49C.

3. Members who have 25 years of protection occupation service credit as defined in Iowa Code section 97B.49B (or the applicable years in effect at the member's retirement).

4. Members who have 30 years of regular service.

5. Members with less than 16 total quarters of service.

b. Assumptions. IPERS shall utilize the following assumptions in calculating benefits under this subrule.

(1) The member's three-year average covered wage shall be determined in the same manner as it is determined for the nonhybrid formula.

(2) Increases in the benefit formula under this subrule shall be determined as provided under Iowa Code section 97B.49D. The percentage multiplier shall only be increased for total years of service over 30.

(3) Years of service shall be utilized as follows:

1. Quarters which have two or more occupation class codes shall be credited as the class that has the highest reported wage for said quarter. A member shall not receive more than one quarter of credit for any calendar quarter, even though more than one type of service credit is recorded for that quarter.

2. Quarters shall not be treated as special service quarters unless the applicable employer and employee contributions have been made.

c. Years of service fraction not to exceed one.

(1) In no event shall a member's years of service fraction under the hybrid formula exceed, in the aggregate, one.

(2) If the years of service fraction does, in the aggregate, exceed one, the member's quarters of service credit shall be reduced until the member's years of service fraction equals, in the aggregate, one.

(3) Service credit shall first be subtracted from the member's regular service credit and, if necessary, shall next be subtracted from the member's protection occupation service, and sheriff/deputy sheriff/airport firefighter service credit, in that order.

d. Age reduction. The portion of the member's benefit calculated under this subrule that is based on the member's regular service shall be subject to a reduction for early retirement in the same manner as is provided for regular service retirements.

e. Calculations. A member's benefit under the hybrid formula shall be the sum of the following:

(1) The applicable percentage multiplier divided by 22 times the years of sheriff/deputy sheriff/airport firefighter service credit (if any) times the member's high three-year average covered wage, plus

(2) The applicable percentage multiplier divided by 25 (or the applicable years at that time under Iowa Code section 97B.49B) times the years of protection occupation class service credit (if any) times the member's high three-year average covered wage, plus

(3) The applicable percentage multiplier divided by 30 times the years of regular service credit (if any) times the member's high three-year average covered wage minus the applicable wage reduction (if any).

If the sum of the percentages obtained by dividing the applicable percentage multiplier by 22, 25 (or the applicable years at that time under Iowa Code section 97B.49B), and 30 and then multiplying those percentages by years of service credit exceeds the applicable percentage multiplier for that member, the percentage obtained above for each class of service shall be subject to reduction so that the total shall not exceed the member's applicable percentage multiplier in the order specified in paragraph "*c,*" subparagraph (3), of this subrule.

21.13(11) Money purchase benefits.

a. For each vested member retiring with less than four complete years of service, a monthly annuity shall be determined by applying the total reserve as of the effective retirement date (plus any retirement dividends standing to the member's credit on December 31, 1966) to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable). If the member's retirement occurs before January 1, 1995, IPERS' revised 6.5 percent tables shall be used. If the member's retirement occurs after December 31, 1994, IPERS' 6.75 percent tables shall be used.

b. For each vested member for whom the present value of future benefits under Option 2 is less than the member reserve as of the effective retirement date, a monthly annuity shall be determined by applying the member reserve to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable). If the member's retirement occurs before January 1, 1995, IPERS' revised 6.5 percent tables shall be used. If the member's retirement occurs after December 31, 1994, IPERS' 6.75 percent tables shall be used.

c. For calculations under paragraph *"a,"* the term "total reserve" means the total of the member's investment and the employer's investment as of the effective retirement date, plus any retirement dividends standing to the member's credit as of December 31, 1966. For calculations under paragraph *"b,"* the term "member reserve" means the member's total investment, excluding all other amounts standing to the member's credit.

d. For calculations under paragraph *"a,"* Options 2, 3, 4, and 5 shall be calculated by dividing the member's total reserve by the applicable Option 2, 3, 4, and 5 annuity factor taken from the department's tables to determine the monthly amount. For calculations under paragraph *"b,"* Options 2, 3, 4, and 5 shall be calculated by dividing the member reserve by the applicable Option 2, 3, 4, and 5 annuity factor taken from the department's tables to determine the monthly amount.

e. For Option 1, the cost per $1,000 of death benefit shall be determined according to the department's tables. That cost shall be subtracted from the Option 3 monthly amount to determine the Option 1 monthly benefit amount. The Option 1 death benefit amount shall be reduced as necessary so that the Option 1 monthly benefit amount is not less than one-half of the Option 2 monthly benefit amount.

f. If the member has prior service (service prior to July 4, 1953), the Option 2 benefit amount calculated under both paragraphs *"a"* and *"b"* shall be calculated by determining the amount of the member's Option 2 benefit based on the member's prior service and the applicable plan formula, plus the amount of the member's Option 2 benefit based on the member's membership service as determined under this subrule. The Option 2 benefit amount based on prior service shall be adjusted for early retirement.

21.13(12) Recalculation for a member aged 70. A member remaining in covered employment after attaining the age of 70 years may receive a retirement allowance without terminating the covered employment. A member who is in covered employment, attains the age of 70 and begins receiving a retirement allowance must terminate all covered employment before the member's retirement allowance can be recalculated to take into account service after the member's original FME. The formula to be used in recalculating such a member's retirement allowance depends on the date of the member's FME and the member's termination date, as follows:

If the member is receiving a retirement allowance with an FME prior to July 1, 2000, and terminates covered employment on or after January 1, 2000, the member's retirement formula for recalculation purposes shall be the formula in effect at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation.

In all other cases, the recalculation for a member aged 70 who retires while actively employed shall use the retirement formula in effect at the time of the member's FME.

This rule is intended to implement Iowa Code sections 97B.1A(23), 97B.47, and 97B.49A to 97B.51.

581—21.14(97B) Interest on accumulated contributions.

21.14(1) The term interest as used in this rule means statutory interest plus the interest dividend. For calendar years prior to January 1, 1997, statutory interest is a credit to the accumulated contributions of active members and inactive vested members at a rate of 2 percent per annum. The interest dividend is a credit to the accumulated contributions of active members and inactive vested members which equals the excess of the average rate of interest earned on the retirement fund through investment during a calendar year over the statutory interest plus twenty-five hundredths of 1 percent. For calendar years beginning January 1, 1997, a per annum interest rate at 1 percent above the interest rate on one-year certificates of deposit shall be credited to the member's contributions and the employer's contributions to become part of the accumulated contributions. For purposes of this subrule, the interest rate on one-year certificates of deposit shall be determined by the department based on the average rate for such certificates of deposit as of the first business day of each year as published in a publication of general acceptance in the business community. The per annum interest rate shall be credited on a quarterly basis by applying one-quarter of the annual interest rate to the sum of the accumulated contributions as of the end of the previous calendar quarter.

21.14(2) If a member is vested upon termination, interest will continue to accrue through the month preceding the month of payment of the refund or, in the case of retirement benefits, through the month preceding the first month of entitlement. For periods ending prior to July 1, 1995, if a member is not vested upon termination, interest will cease to accrue on termination of covered employment for as long as the member remains inactive. For periods beginning July 1, 1995, interest will cease to accrue if a member is not vested upon termination of employment for as long as the member is inactive or nonvested. A member automatically becomes vested upon the attainment of the age of 55. Interest shall not be credited to a member's account if the wages were reported in error. Effective July 1, 1995, interest will be credited to an inactive nonvested member's account as provided in Iowa Code section 97B.70, beginning on the first date thereafter that such a member becomes vested as provided in Iowa Code section 97B.1A(24).

21.14(3) Interest shall accrue on the undistributed accumulated contributions of all members, including those of inactive nonvested members, and on the undistributed accumulated contributions of deceased members that are payable under Iowa Code section 97B.52(1). No interest shall be credited to any other death benefit payable under Iowa code chapter 97B. The provisions of this subrule crediting interest to the undistributed accumulated contributions of inactive nonvested members shall not become effective until January 1, 1999.

21.14(4) Effective July 1, 1998, interest on the undistributed accumulated contributions described in subrule 21.14(3) shall accrue through the quarter preceding the quarter in which any distribution is made. If IPERS determines that a dispute among alleged heirs exists, the amount of the death benefits shall be placed in a non-interest-bearing account.

This rule is intended to implement Iowa Code sections 97B.52, 97B.53 and 97B.70.

581—21.15(97B) Forgery claims. When a forgery of a warrant issued in payment of an IPERS refund or benefit is alleged, the claimant must complete and sign an affidavit before a notary public that the endorsement is a forgery. A supplementary statement must be attached to the affidavit setting forth the details and circumstances of the alleged forgery.

This rule is intended to implement Iowa Code sections 97B.40, 97B.52 and 97B.53.

581—21.16(97B) Approved leave periods.

21.16(1) Effective July 1, 1998, a member's service is not deemed interrupted while a member is on a leave of absence that qualifies for protection under the Family and Medical Leave Act of 1993 (FMLA), or would qualify but for the fact that the type of employment precludes coverage under the FMLA, or during the time a member is engaged during military service for which the member is entitled to receive credit under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) (38 U.S.C. Sections 4301 to 4333).

21.16(2) Reentry into public employment by an employee on military leave can be achieved if the individual accepts employment with a covered employer. Reemployment may begin anytime within 12 months of the individual's discharge from military service or, if longer, within the period provided under USERRA. Upon reemployment the member shall receive credit for all service to which the member is entitled pursuant to USERRA.

Notwithstanding any provision of Iowa Code chapter 97B or these rules to the contrary, contributions, benefits and service credit with respect to qualified military service will be provided in accordance with Internal Revenue Code Section 414(u).

For reemployments initiated on or after December 12, 1994, a member shall be treated as receiving compensation for each month during the member's period of military service equal to the member's average monthly compensation during the 12-month period immediately preceding the period of military service or, if shorter, the member's average monthly compensation for the period immediately preceding the period of military service. The member's deemed compensation during the period of military service shall be taken into consideration in determining a member's make-up contributions, if any, and the member's high three-year average covered wage.

For reemployments initiated on or after December 12, 1994, make-up contributions shall be permitted with respect to employee contributions that would have been made during the period of military service if the member had actually been in covered employment during the period earning the deemed compensation provided for under this subrule. Make-up contributions shall be permitted during the five-year period that begins on the date of reemployment or, if less, a period equal to three times the period of military service.

The member shall request the foregoing make-up contributions (except contributions for periods prior to January 1, 1995, which shall be made as posttax contributions) on forms to be filed with the employer, which shall forward a copy to the system. Make-up contributions shall be made as pretax contributions under Internal Revenue Code Section 414(h)(2). Employers must comply with a member's request to begin make-up contributions during a period not exceeding that described in the preceding paragraph and shall forward said amounts to the system in the same manner as provided for pick-up contributions under Iowa Code section 97B.11A. An election to make up employee contributions under this rule shall be irrevocable.

21.16(3) Effective for leaves of absence beginning on or after July 1, 1998, an eligible member must make contributions to the system in order to receive service credit for the period of the leave (except for leaves under subrule 21.16(1) above). Contributions may be made in increments of one quarter or more.

21.16(4) Reentry into public employment by an employee on a leave of absence under subrule 21.16(1) can be achieved by the employee by accepting employment with any public employer, provided that any interruption between the end of the period of leave of absence and reentry into public employment meets the requirements of the FMLA, USERRA and this rule.

21.16(5) Credit for a leave of absence shall not be granted and cannot be purchased for any time period which begins after or extends beyond an employee's termination of employment as certified by the employer. This includes a certification of termination of employment made by an employer on a refund application. Employers shall be required to certify all leaves of absence for which credit is being requested using an affidavit furnished by IPERS and accompanied by a copy of the official record(s) which authorized the leave of absence. The provisions of this subrule denying credit for leaves of absence in cases in which the member takes a refund shall not apply to employees who were on leaves of absence that began before November 27, 1996, and took a refund before such date. The provisions of the subrule requiring employers to certify all leaves of absence using an affidavit furnished by IPERS shall apply to all requests for leave of absence credit filed after November 27, 1996, regardless of when the leave of absence was granted.

21.16(6) For a leave of absence beginning on or after July 1, 1998, and purchased before July 1, 1999, the service purchase cost shall be equal to the employer and employee contributions and interest payable for the employee's most recent year of covered wages, adjusted by the inflation factor used in rule 21.24(97B). For a leave of absence beginning on or after July 1, 1998, and purchased on or after July 1, 1999, the service purchase cost shall be the actuarial cost, as certified by IPERS' actuary. In calculating the actuarial cost of a service purchase under this subrule, the actuary shall apply the same actuarial assumptions and cost methods used in preparing IPERS' annual actuarial valuation, except that: (1) the retirement assumption shall be changed to 100 percent at the member's earliest unreduced retirement age; and (2) if the actuary uses gender-distinct mortality assumptions, the system shall use blended mortality assumptions reasonably representative of the system's experience. The actuarial cost of a service purchase shall be the difference between (1) the actuarial accrued liability for the member using the foregoing assumptions and current service credits, and (2) the actuarial accrued liability for the member using the foregoing assumptions, current service credits, and all quarters of service credit available for purchase. If IPERS changes the service purchase mortality assumptions upon the recommendation of its actuary, all outstanding service purchase quotes shall be binding for the remainder of the periods for which the cost quotes were issued. A cost quote for a service purchase shall expire six months after it is delivered to the member. After that time, a new cost quote must be obtained for any quarters not previously purchased.

This rule is intended to implement Iowa Code sections 97B.1A(8), 97B.1A(8A), 97B.1A(19) and 97B.81.

581—21.17(97B) Membership status.

21.17(1) Effective July 1, 1990, a member achieves vested status when the member has served and made contributions in 16 or more quarters of IPERS-covered employment or attains the age of 55. The vested status of a member may also be determined when the member's contribution payments cease. At that time a comparison of the membership date and termination date will be made. If service sufficient to indicate vested status is present, after any periods of interruption in service have been taken into consideration, the member shall be considered a vested member. All vested members receive all the rights and benefits of a vested member in IPERS until or unless the member files for a refund of accumulated contributions.

21.17(2) For the purposes of this rule, four quarters of coverage shall constitute a year of membership service for a member employed on a fiscal- or calendar-year basis. A member working for a school district or other institution which operates on a nine-month basis shall be granted a year of membership service for each year in which the member has three or more quarters of coverage, if the employee remains in covered employment for the next operating year. An employee who terminates covered employment and has no wages paid in the third quarter shall not receive service credit for the third quarter. Only one year of membership service credit shall be granted for any 12-month period.

21.17(3) Rescinded IAB 7/22/92, effective 7/2/92.

21.17(4) Effective July 1, 1988, an inactive member who had accumulated, as of the date of the member's last termination of employment, years of membership service equal to or exceeding the years of membership service specified in this subrule for qualifying as a vested member on the date of termination, shall be considered vested.

21.17(5) In the case of a complete or partial termination of this fund, any affected member shall have a vested interest in the accrued benefit as of the date of such termination, to the extent such benefit is then funded.

This rule is intended to implement Iowa Code section 97B.41.

581—21.18(97B) Retirement dates.

21.18(1) Effective through December 31, 1992, the first month of entitlement of a member who qualifies for retirement benefits is the first month following the member's last day of service or last day of leave, with or without pay, whichever is later.

21.18(2) Effective January 1, 1993, the first month of entitlement of an employee who qualifies for retirement benefits shall be the first month after the employee is paid the last paycheck, if paid more than one calendar month after termination. If the final paycheck is paid within the month after termination, the first month of entitlement shall be the month following termination.

21.18(3) To be eligible for a monthly retirement benefit, the member must survive into the designated first month of entitlement. If the member dies prior to the first month of entitlement, the member's application for monthly benefits is canceled and the distribution of the member's account is made pursuant to Iowa Code section 97B.52. Cancellation of the application shall not invalidate a beneficiary designation. If the application is dated later in time than any other designations, IPERS will accept the designation in a canceled application as binding until a subsequent designation is filed.

21.18(4) The first month of entitlement of a member qualifying under the rule of 88 (see subrule 21.11(3)) shall be the first of the month when the member's age as of the last birthday and years of service equal 88. The fact that a member's birthday allowing a member to qualify for the rule of 88 is the same month as the first month of entitlement does not affect the retirement date.

21.18(5) Notwithstanding anything to the contrary, members shall commence receiving a distribution on or before the minimum distribution required beginning date set forth in the Internal Revenue Code. In general, members must begin distributions on or before April 1 of the calendar year after the calendar year in which they attain age of 70½, or actually terminate employment (if later).

21.18(6) For purposes of determining benefits, the life expectancy of a member, a member's spouse, or a member's beneficiary shall not be recalculated after benefits commence.

This rule is intended to implement Iowa Code sections 97B.45, 97B.47 and 97B.48(1) and (2).

581—21.19(97B) Wage-earning disqualifications for retired members.

21.19(1) Effective July 1, 1998, the monthly benefit payments for a member under the age of 65 who has a bona fide retirement and is then reemployed in covered employment shall be reduced by 50 cents for each dollar the member earns in excess of the amount of remuneration permitted for a calendar year for a person under the age of 65 before a reduction in federal Social Security retirement benefits is required, or $14,000, whichever is greater. The foregoing reduction shall apply only to IPERS benefits payable for the applicable year that the member has reemployment earnings, and after the earnings limit has been reached. Said reductions shall be applied as provided in subrule 21.19(2) below.

Effective January 1, 1991, this earnings limitation does not apply to covered employment in an elective office. A member aged 65 or older who has completed at least four full calendar months of bona fide retirement and is later reemployed in covered employment shall not be subject to any wage-earning disqualification.

21.19(2) Beginning on or after July 1, 1996, the retirement allowance of a member subject to reduction pursuant to subrule 21.19(1) shall be reduced as follows:

a. A member's monthly retirement allowance in the next following calendar year shall be reduced by the excess amounts earned in the preceding year divided by the number of months remaining in the following calendar year after the excess amount has been determined. A member may elect to make repayment of the overpayments received in lieu of having the member's monthly benefit reduced. Elections to make installment payments must be accompanied by a repayment agreement signed by the member and IPERS. If the monthly amount to be deducted exceeds a member's monthly retirement allowance, the member's monthly allowance shall be withheld in its entirety until the overpayment is recovered. If a member dies and the full amount of overpayments determined under this subrule has not been repaid, the remaining amounts shall be deducted from the payments to be made, if any, to the member's designated beneficiary or contingent annuitant. If the member has selected an option under which there are no remaining amounts to be paid, or the remaining amounts are insufficient, the unrecovered amounts shall be a charge on the member's estate.

b. Employers shall be required to complete IPERS wage reporting forms for reemployed individuals which shall reflect the prior year's wage payments on a month-to-month basis. These reports shall be used by IPERS to determine the amount which must be recovered to offset overpayments in the prior calendar year due to reemployment wages.

c. A member may elect in writing to have the member's monthly retirement allowance suspended in the month in which the member's remuneration exceeds the amount of remuneration permitted under this rule in lieu of receiving a reduced retirement allowance under paragraph *"a"* of this subrule. If the member's retirement allowance is not suspended timely, the overpayment will be recovered pursuant to paragraph *"a"* of this subrule. The member's retirement allowance shall remain suspended until the earlier of January of the following calendar year or the member's termination of covered employment. The member's election shall remain binding until revoked in writing.

21.19(3) A member who is reemployed in covered employment after retirement may, after again retiring from employment, request a recomputation of benefits. The member's retirement benefit shall be increased if possible by the addition of a second annuity, which is based on years of reemployment service, reemployment covered wages and the benefit formula in place at the time of the recomputation. A maximum of 30 years of service is creditable to an individual retiree. If a member's combined years of service exceed 30, a member's initial annuity may be reduced by a fraction of the years in excess of 30 divided by 30. The second retirement benefit will be treated as a separate annuity by IPERS. Any contributions that cannot be used in the recomputation of benefits shall be refunded to the employee and the employer.

Effective July 1, 1998, a member who is reemployed in covered employment after retirement may, after again terminating employment, elect to receive a refund of the employee and employer contributions made during the period of reemployment in lieu of a second annuity. If a member requests a refund in lieu of a second annuity, the related service credit shall be forfeited.

21.19(4) In recomputing a retired member's monthly benefit, IPERS shall use the following assumptions.

a. The member cannot change option or beneficiary with respect to reemployment period.

b. If the reemployment period is less than four years, the money purchase formula shall be used to compute the benefit amount.

c. If the reemployment period is four or more years, the benefit formula in effect as of the first month of entitlement (FME) for the reemployment period shall be used. If the FME is July 1998 or later, and the member has more than 30 years of service, including both original and reemployment service, the percentage multiplier for the reemployment period only will be at the applicable percentage (up to 65 percent) for the total years of service.

d. If a period of reemployment would increase the monthly benefit a member is entitled to receive, the member may elect between the increase and a refund of the employee and employer contributions without regard to reemployment FME.

e. If a member previously elected IPERS Option 1, is eligible for an increase in the Option 1 monthly benefits, and elects to receive the increase in the member's monthly benefits, the member's Option 1 death benefit shall also be increased if the investment is at least $1,000. The amount of the increase shall be at least the same percentage of the maximum death benefit permitted with respect to the reemployment as the percentage of the maximum death benefit elected at the member's original retirement. In determining the increase in Option 1 death benefits, IPERS shall round up to the nearest $1,000. For example, if a member's investment for a period of reemployment is $1,900 and the member elected at the member's original retirement to receive 50 percent of the Option 1 maximum death benefit, the death benefit attributable to the reemployment shall be $1,000 (50 percent times $1,900, rounded up to the nearest $1,000). Notwithstanding the foregoing, if the member's investment for the period of reemployment is less than $1,000, the benefit formula for a member who originally elected new IPERS Option 1 shall be calculated under IPERS Option 3.

f. A retired reemployed member whose reemployment FME precedes July 1998 shall not be eligible to receive the employer contributions made available to retired reemployed members under Iowa Code section 97B.48A(4) effective July 1, 1998.

g. A retired reemployed member who requests a return of the employee and employer contributions made during a period of reemployment cannot repay the distribution and have the service credit for the period of reemployment restored.

This rule is intended to implement Iowa Code sections 97B.1A, 97B.45 and 97B.48A as amended by 2000 Iowa Acts, Senate File 2411, section 33.

581—21.20(97B) Identification of agents.

21.20(1) Recognition of agents. When a claimant before IPERS desires to be represented by an agent in the presentation of a case, the claimant shall designate in writing the name of a representative and the nature of the business the representative is authorized to transact. Such designation on the part of the claimant shall constitute for IPERS sufficient proof of the acceptability of the individual to serve as the claimant's agent. An attorney in good standing may be so designated by the claimant.

21.20(2) Payment to incompetents. When it appears that the interest of a claimant or retiree would be served, IPERS may recognize an agent to represent the individual in the transaction of the affairs with IPERS. Recognition may be obtained through the filing with IPERS of a copy of the guardianship, trusteeship, power of attorney, conservatorship or Social Security representative payee documents by the individual so designated. Such persons have all the rights and obligations of the member. Notwithstanding the foregoing, none of the foregoing representatives shall have the right to name the representative as the member's beneficiary unless approved to do so by a court having jurisdiction of the matter, or unless expressly authorized to do so in a power of attorney executed by the member.

21.20(3) An individual serving in the capacity of an agent establishes an agreement with IPERS to transact all business with IPERS in such a manner that the interests of the retiree or claimant are best served. Payments made to the agent on behalf of the individual will be used for the direct benefit of the retiree or claimant. Failure to adhere to the agreement will cause discontinuance of the agency relationship and may serve as the basis for legal action by IPERS or the member.

This rule is intended to implement Iowa Code sections 97B.34 and 97B.37.

581—21.21(97B) Actuarial equivalent (AE) payments.

21.21(1) If a member aged 55 or older requests an estimate of benefits which results in any one of the options having a monthly benefit amount of less than $50, the member may elect, under Iowa Code section 97B.48(1), to receive a lump sum actuarial equivalent (AE) payment in lieu of a monthly benefit. Once the AE payment has been paid to the member, the member shall not be entitled to any further benefits based on the contributions included in the AE payment and the employment period represented thereby. Should the member later return to covered employment, any future benefits the member accrues will be based solely on the new employment period. If an estimate of benefits based on the new employment period again results in any one of the options having a monthly benefit amount of less than $50, the member may again elect to receive an AE payment.

21.21(2) If a member, upon attaining the age of 70 or later, requests a retirement allowance without terminating employment and any one of the options results in a monthly benefit amount of less than $50, the member may elect to receive an AE payment based on the member's employment up to, but not including, the quarter in which the application is filed. When the member subsequently terminates covered employment, any benefits due to the member will be based only on the period of employment not used in computing the AE paid when the member first applied for a retirement allowance. If an estimate of benefits based on the later period of employment again results in any of the options having a monthly benefit amount of less than $50, the member may again elect to receive another AE payment. A member who elects to receive an AE payment without terminating employment may not elect to receive additional AE payments unless the member terminates all covered employment and completes a bona fide retirement as provided in these rules.

21.21(3) An AE payment shall be equal to the sum of the member's and employer's accumulated contributions and the retirement dividends standing to the member's credit before December 31, 1966.

This rule is intended to implement Iowa Code sections 97B.4, 97B.15 and 97B.48(1).

581—21.22(97B) Disability for persons not retiring under 2000 Iowa Acts, Senate File 2411, section 51.

21.22(1) The following standards apply to the establishment of a disability under the provisions of IPERS:

a. The member must inform IPERS at retirement that the retirement is due to an illness, injury or similar condition. The member must also initiate an application for federal Social Security disability benefits or federal Railroad Retirement Act disability benefits.

b. To qualify for the IPERS disability provision, the member must be awarded federal Social Security benefits due to the disability which existed at the time of retirement.

c. Effective July 1, 1990, the member may also qualify for the IPERS disability provision by being awarded, and commencing to receive, disability benefits through the federal Railroad Retirement Act, 45 U.S.C. Section 231 et seq., due to a disability which existed at the time of retirement.

21.22(2) If a member returns to covered employment after achieving a bona fide retirement, the benefits being provided to a member under Iowa Code section 97B.50(2)*"a"* or *"b"* shall be suspended or reduced as follows. If the member has not attained the age of 55 upon reemployment, benefit payments shall be suspended in their entirety until the member subsequently terminates employment, applies for, and is approved to receive benefits under the provisions of Iowa Code chapter 97B. If the member is aged 55 or older upon reemployment, the member shall continue to receive the monthly benefit payable to the member on the member's initial retirement date based on the member's age at the initial retirement date, years of membership service not to exceed 30, and benefit option, and subject to the applicable reductions for early retirement in place at the time of the initial retirement. The member's benefit shall also be subject to the applicable provisions of Iowa Code section 97B.48A pertaining to reemployed retirees.

21.22(3) Rescinded IAB 7/22/92, effective 7/2/92.

This rule is intended to implement Iowa Code section 97B.50.

581—21.23(97B) Confidentiality of records.

21.23(1) Records established and maintained by IPERS containing personal information are not public records under Iowa Code chapter 22. Records may be released to the member or the beneficiary (if the beneficiary is entitled to funds) or to a person designated by the member or beneficiary in writing. Records may also be released to an executor, administrator or attorney of record for an estate of a deceased member or beneficiary.

21.23(2) Summary information concerning the demographics of the IPERS membership and general statistical information concerning the system and its activities is made available in accordance with Iowa Code section 97B.17.

21.23(3) Notwithstanding any provisions of Iowa Code chapter 22 or 97B to the contrary, the department's records may be released to any political subdivision, instrumentality, or other agency of the state solely for use in a civil or criminal law enforcement activity pursuant to the requirements of this subrule. To obtain the records, the political subdivision, instrumentality, or agency shall, in writing, certify that the activity is authorized by law, provide a written description of the information desired, and describe the law enforcement activity for which the information is sought. The department shall not be civilly or criminally liable for the release or rerelease of records in accordance with this subrule.

This rule is intended to implement Iowa Code sections 97B.15 and 97B.17.

581—21.24(97B) Service buy-in/buy-back.

21.24(1) *Prior service buy-back.*

a. Effective July 1, 1990, a member who was active, vested or retired on or after July 1, 1978, and who made contributions to IOASI between January 1, 1946, and June 30, 1953, and took a refund of those contributions, may buy back the amount of that refund plus interest in order to establish quarters of service covered by the refund. Less than a full quarter of service will be considered equivalent to a full quarter of service. A teacher who has three quarters of service and a contract for the following year will be granted four quarters of service. IPERS may require the submission of a copy of the contract.

b. Prior to July 1, 1990, a member who was active, vested or retired as of July 1, 1978, and who made contributions to IOASI between January 1, 1946, and June 30, 1953, and who took a refund of those contributions, was able to buy back the amount of that refund and establish years of service covered by the refund.

c. A member cannot participate in the prior service buy-back if the member had taken an IPERS refund (contributions made after July 4, 1953) unless the member first participated in the IPERS buy-back in accordance with this rule.

If a member decides to buy back prior service credit, the member must repay the entire refunded amount plus the accumulated interest and interest dividends on that amount.

If a member participating in a prior service buy-back had years of public service within Iowa prior to January 1, 1946, those years of service will also be added to the member's account at no cost, subject to the member's providing verification of public service.

21.24(2) *Purchase IPERS credit for service in other public employment.*

a. Effective July 1, 1992, a vested or retired member may make application to IPERS for purchasing credit for service rendered to another public employer. In order to be eligible, a member must:

(1) Have been a public employee in a position comparable to an IPERS covered position at the time the application for buy-in is processed. Effective July 1, 1990, "public employee" includes members who had service as a public employee in another state, or for the federal government, or within other retirement systems established in the state of Iowa;

(2) Waive on a form provided by IPERS all rights to a retirement in another system for that period of employment sought to be purchased, if any; such a waiver must be accepted by the other retirement system before the member can proceed with a buy-in of that service time into IPERS; and

(3) Submit verification of service for that other public employer to IPERS.

A quarter of credit will be given for each quarter the employee was paid. If no pay dates are shown, credit will be given if the employee had service of at least 15 days in the quarter.

b. A qualifying member who decides to purchase IPERS credit must make employer and employee contributions to IPERS for each calendar quarter of service allowed in this buy-in. This contribution shall be determined using the member's covered IPERS wages for the most recent full calendar year of IPERS coverage, the applicable rates established in Iowa Code sections 97B.11, 97B.49B and 97B.49C, and multiplied by the number of quarters being purchased from other public employment. "Applicable rates" means the rates in effect at the time of purchase for the types of service being purchased. A member must have at least four quarters of reported wages in any calendar year before a buy-in cost may be calculated.

c. If a vested or retired member does not have wages in the most recent calendar year, the cost of the buy-in will be calculated using the member's last calendar year of reported wages, adjusted by an inflation factor based on the Consumer Price Index as published by the United States Department of Labor.

d. Members eligible to complete the buy-in may buy the entire period of service for a public employer or may buy credit in increments of one or more calendar quarters. The quarters need not be specifically identified to particular calendar quarters. A period of service is defined as follows: (1) if a member was continuously employed by an employer, the entire time is one period of employment, regardless of whether a portion or all of the service was covered by one or more retirement systems; and (2) if a member is continuously employed by multiple employers within a single retirement system, the entire service credited by the other retirement system is a period of employment. A member with service credit under another public employee retirement system who wishes to transfer only a portion of the service value of the member's public service in another public system to IPERS, must provide a waiver of that service time to IPERS together with proof that the other public system has accepted this waiver and allowed partial withdrawal of service credit. Members are allowed to purchase time credited by the other public employer as a leave of absence in the same manner as other service credit. Notwithstanding the foregoing, members wishing to receive free credit for military service performed while in the employ of a qualifying non-IPERS covered public employer must purchase the entire period of service encompassing the service time for that public employer or in the other retirement system, excluding the military time. Veterans' credit originally purchased in another retirement system may be purchased into IPERS in the same manner as other service credit.

e. The total amount paid will be added to the member's contributions and the years of service this amount represents will be added to the member's IPERS years of service. Effective January 1, 1993, the purchase will not affect the member's three-year average covered wage.

f. Effective July 1, 1999, an eligible member must pay the actuarial cost of a buy-in, as certified by IPERS' actuary. In calculating the actuarial cost of a buy-in, the actuary shall apply the same actuarial assumptions and cost methods used in preparing IPERS' annual actuarial valuation, except that: (1) the retirement assumption shall be changed to 100 percent at the member's earliest unreduced retirement age; and (2) if the actuary uses gender-distinct mortality assumptions, the system shall use blended mortality assumptions reasonably representative of the system's experience. The actuarial cost of a service purchase shall be the difference between (1) the actuarial accrued liability for the member using the foregoing assumptions and current service credits, and (2) the actuarial accrued liability for the member using the foregoing assumptions, current service credits, and all quarters of service credit available for purchase. If IPERS changes the service purchase mortality assumptions upon the recommendation of its actuary, all outstanding service purchase quotes shall be binding for the remainder of the periods for which the cost quotes were issued. A cost quote for a service purchase shall expire six months after it is delivered to the member. After that time, a new cost quote must be obtained for any quarters not previously purchased.

21.24(3) *IPERS buy-back.* Effective July 1, 1996, only vested or retired members may buy back previously refunded IPERS credit. For the period beginning July 1, 1996, and ending June 30, 1999, an eligible member is required to make membership contributions equal to the accumulated contributions received by the member for the period of service being purchased plus accumulated interest and interest dividends. Effective July 1, 1999, an eligible member must pay the actuarial cost of a buy-back, as certified by IPERS' actuary. In calculating the actuarial cost, the actuary shall apply the same actuarial assumptions and cost methods used in preparing IPERS' annual actuarial valuation, except that: (1) the retirement assumption shall be changed to 100 percent at the member's earliest unreduced retirement age; and (2) if the actuary uses gender-distinct mortality assumptions, the system shall use blended mortality assumptions reasonably representative of the system's experience. The actuarial cost of a service purchase shall be the difference between (1) the actuarial accrued liability for the member using the foregoing assumptions and current service credits, and (2) the actuarial accrued liability for the member using the foregoing assumptions, current service credits, and all quarters of service credit available for purchase. If IPERS changes the service purchase mortality assumptions upon the recommendation of its actuary, all outstanding service purchase quotes shall be binding for the remainder of the periods for which the cost quotes were issued. A cost quote for a service purchase shall expire six months after it is delivered to the member. After that time, a new cost quote must be obtained for any quarters not previously purchased.

Effective July 1, 1996, buy-backs may be made in increments of one or more calendar quarters. Prior to July 1, 1996, the member was required to repurchase the entire period of service and repay the total amount received plus accumulated interest and interest dividends.

A member who is vested solely by having attained the age of 55 must have at least one calendar quarter of wages on file with IPERS before completing a buy-back.

IPERS shall restore the wage records of a member who makes a buy-back and utilize those records in subsequent benefit calculations for that member.

21.24(4) *Prior service credit prior to January 1946.* A member who had service before January of 1946 but no service between January 1, 1946, and June 30, 1953, is eligible to receive credit for that service at no cost, subject to the member's providing verification of that service. If the member was employed after July 4, 1953, and took a refund of contributions, that member must first participate in the membership service buy-back (see subrule 21.24(3)) before receiving credit for service prior to 1946.

A member must submit proof of service in order to qualify.

21.24(5) *Veterans' credit.*

a. Effective July 1, 1992, a vested or retired member, in order to receive service credit under the IPERS system, may elect to make employer and employee contributions to IPERS for a period of active duty service in the armed forces of the United States, in increments of one or more calendar quarters, provided that the member:

(1) Produces verification of active duty service in the armed forces of the United States; and

(2) Is not receiving, or is not eligible to receive, retirement pay from the United States government for active duty service in the armed forces including full retirement disability compensation for this period of service. Disability payments received by the member as compensation for disability incurred while in service of the armed forces, which are not in lieu of military retirement compensation, will not disqualify a member from participating in this program.

A quarter of credit will be given when the date indicated on the DD214 shows service of at least 15 days in the quarter.

b. Prior to July 1, 1990, a person had to be an active member of IPERS as of July 1, 1988, and had to have covered wages during the 1987 calendar year in order to be eligible to apply. Partial buy-ins of allowable service time were not permitted until July 1, 1990.

c. For purchases prior to July 1, 1999, the member must pay IPERS the combined employee and employer contribution amount determined using the member's covered wages for the most recent full calendar year at the applicable rates in effect for that year under Iowa Code sections 97B.11, 97B.49B and 97B.49C for each year of the member's active duty service. A member must have at least four quarters of reported wages in any calendar year before a buy-in cost may be calculated.

d. If a vested or retired member does not have wages in the most recent calendar year, the cost of the buy-in will be calculated using the member's last calendar year of reported wages, adjusted by an inflation factor based on the Consumer Price Index as published by the United States Department of Labor. Between July 1, 1990, and July 1, 1992, members who did not have reported wages in the most recent calendar year were not permitted to purchase their otherwise eligible service time. Effective January 1 , 1993, the purchase will not affect the member's high three-year average wage.

e. Members eligible to complete the veterans' buy-in may buy the entire period of service or may buy credit in increments of one or more calendar quarters. If the entire period is not purchased, IPERS will calculate the proportionate cost of this period of service in accordance with this subrule. Fractional years of active service shall qualify a member for the equivalent quarters of credited IPERS covered service.

f. Effective July 1, 1999, an eligible member must pay the actuarial cost of a military service purchase, as certified by IPERS' actuary. In calculating the actuarial cost, the actuary shall apply the same actuarial assumptions and cost methods used in preparing IPERS' annual actuarial valuation, except that: (1) the retirement assumption shall be changed to 100 percent at the member's earliest unreduced retirement age; and (2) if the actuary uses gender-distinct mortality assumptions, the system shall use blended mortality assumptions reasonably representative of the system's experience. The actuarial cost of a service purchase shall be the difference between (1) the actuarial accrued liability for the member using the foregoing assumptions and current service credits, and (2) the actuarial accrued liability for the member using the foregoing assumptions, current service credits, and all quarters of service credit available for purchase. If IPERS changes the service purchase mortality assumptions upon the recommendation of its actuary, all outstanding service purchase quotes shall be binding for the remainder of the periods for which the cost quotes were issued. A cost quote for a service purchase shall expire six months after it is delivered to the member. After that time, a new cost quote must be obtained for any quarters not previously purchased.

21.24(6) *Legislative members.*

a. Active members. Persons who are members of the Seventy-first General Assembly or a succeeding general assembly during any period beginning July 4, 1953, may, upon proof of such membership in the general assembly, make contributions to the system for all or a portion of the period of such service in the general assembly. The contributions made by the member shall be determined in the same manner as provided in subrule 21.24(6)*"b."*

b. Vested or retired former members of the general assembly.

(1) A vested or retired member of the system who was a member of the general assembly prior to July 1, 1988, may make contributions to the system for all or a portion of the period of service in the general assembly.

(2) The contributions made by the member shall be equal to the accumulated contributions as defined in Iowa Code section 97B.41(2), which would have been made if the member of the general assembly had been a member of the system during the period of service in the general assembly being purchased.

(3) The member shall submit proof to IPERS of membership in the general assembly for the period claimed.

(4) Upon determining a member eligible and receiving the appropriate contributions from the member, IPERS shall credit the member with the period of membership service for which contributions are made.

c. Incremental purchases. Service purchased under this subrule must be purchased in increments of one or more calendar quarters.

d. Actuarial cost. Effective July 1, 1999, an eligible member must pay 40 percent and the Iowa legislature shall pay 60 percent of the actuarial cost of a legislative service purchase, as certified by IPERS' actuary. In calculating the actuarial cost, the actuary shall apply the same actuarial assumptions and cost methods used in preparing IPERS' annual actuarial valuation, except that: (1) the retirement assumption shall be changed to 100 percent at the member's earliest unreduced retirement age; and (2) if the actuary uses gender-distinct mortality assumptions, the system shall use blended mortality assumptions reasonably representative of the system's experience. The actuarial cost of a service purchase shall be the difference between (1) the actuarial accrued liability for the member using the foregoing assumptions and current service credits, and (2) the actuarial accrued liability for the member using the foregoing assumptions, current service credits, and all quarters of service credit available for purchase. If IPERS changes the service purchase mortality assumptions upon the recommendation of its actuary, all outstanding service purchase quotes shall be binding for the remainder of the periods for which the cost quotes were issued. A cost quote for a service purchase shall expire six months after it is delivered to the member. After that time, a new cost quote must be obtained for any quarters not previously purchased.

21.24(7) *Vocational school (area college) employees may elect coverage under another retirement system.*

a. Effective July 1, 1990, a person newly entering employment with an area vocational school or area community college may choose to forego IPERS coverage and elect coverage under an alternative retirement benefits system, which is issued by or through a nonprofit corporation issuing retirement annuities exclusively to educational institutions and their employees. This option is available only to those newly hired persons who are already members of the alternative retirement system. Such an election by a newly employed person is irrevocable.

b. Effective July 1, 1994, and providing that the board of directors of the area vocational school or area community college have approved participation in an alternative retirement system pursuant to Iowa Code section 260C.23, a member employed by an area vocational school or an area community college may elect coverage under an alternative retirement benefits system, which is issued by or through a nonprofit corporation issuing retirement annuities exclusively to educational institutions and their employees, in lieu of continuing or commencing contributions to IPERS.

c. Rescinded IAB 7/22/92, effective 7/2/92.

d. Effective July 1, 1994, a person who is employed before that date with an area community college may file a one-time irrevocable election form with IPERS and the employer electing participation in an alternative plan. The election must be postmarked by December 31, 1995. If a person is employed July 1, 1994, or later, the person may file a one-time election with IPERS and the employer electing participation in the alternative plan. The election must be postmarked within 60 days from the date employed. The employee will be a member of IPERS unless an election is filed within the specified time frames. An employee vested with IPERS retains all of the rights of any vested member for as long as the contributions remain with the fund. Members who elect out of IPERS coverage but remain with the same employer are eligible to apply for and receive a refund of their contributions plus interest. Such members may not, however, apply for retirement benefits until attaining the age of 70, or until they terminate employment with all public employers.

21.24(8) *Refunds of service purchase amounts.* A member may request and receive a refund without interest of all or a portion of amounts paid to IPERS to buy back prior service credit or to purchase credit for other service pursuant to Iowa Code chapter 97B. Such refund requests must be made in writing within 60 days after the date of the receipt issued by IPERS to the member for such amounts. Such refunds shall be in increments representing one or more quarters. Notwithstanding the foregoing, no refund shall be made if a member has made a service purchase under this rule and one or more monthly retirement allowance payments have been made thereafter. Furthermore, this subrule shall not limit IPERS' ability to refund service purchase amounts when required in order to meet the provisions of the Internal Revenue Code that apply to IPERS. This subrule shall be effective for refund requests received by IPERS on or after May 3, 1996.

21.24(9) *Leaves of absence.* Service credit for leaves of absence that begin on or after July 1, 1998, may be purchased. The cost of such service purchases shall be calculated in the same manner as provided for buy-ins under subrule 21.24(2) above. In addition, a member must be vested or retired, and must have one calendar year of wages on file in order to make such a purchase.

21.24(10) *Service credit under Iowa Code section 97B.42A(4).* Service credit for periods of time prior to January 1, 1999, when the member was employed in a position for which coverage could have been elected, but was not, may be purchased. The cost of such service purchases shall be calculated in the same manner as provided for buy-ins under subrule 21.24(2) above. In addition, a member must be vested or retired, and must have one calendar year of wages on file in order to make such a purchase. A member shall not be able to purchase service under this rule that was not eligible for optional coverage at the time of the employment.

21.24(11) *Public employment service credit under 2000 Iowa Acts, Senate File 2411, section 70.* A vested or retired member who has five or more years of service credit and who was previously employed in public employment for which optional coverage was not available, such as substitute teaching or other temporary employment, may purchase up to 20 quarters of service credit for such employment subject to the requirements of 2000 Iowa Acts, Senate File 2411, section 70. Service credit may not be purchased under this subrule for time periods when the member was eligible to elect coverage and failed to do so, or affirmatively elected out of coverage. Also, service credit may not be purchased under this subrule for periods in which the individual was performing services as an independent contractor. The contributions required under this subrule shall be in an amount equal to the actuarial cost of the service purchase as determined under 21.24(2)*"f."*

21.24(12) *Federal Peace Corps program service credit under 2000 Iowa Acts, Senate File 2411, section 71.* A vested or retired member who has five or more years of service credit and who was previously employed full-time as a member of the federal Peace Corps program may purchase up to 20 quarters of service credit for such employment, subject to the requirements of 2000 Iowa Acts, Senate File 2411, section 71. Members with service credit for such employment under another public retirement system must provide a waiver of the service time to IPERS along with proof that the other public retirement system has accepted the waiver and allows withdrawals of the related service credit. The contributions required under this subrule shall be in an amount equal to the acturarial cost of the service purchase as determined under 21.24(2)*"f."*

21.24(13) *Purchase of service credit for employment with a qualified Canadian governmental entity.* A vested or retired member who has five or more years of service credit and who was previously employed full-time by a qualified Canadian governmental entity, as defined in Iowa Code section 97B.73 as amended by 2000 Iowa Acts, Senate File 2411, section 68, may purchase up to 20 quarters of service credit for such employment, subject to the requirements of Iowa Code section 97B.73 as amended by 2000 Iowa Acts, Senate File 2411, section 68. Members with service credit for such employment under another public retirement system must provide a waiver of the service time to IPERS along with proof that the other public retirement system has accepted the waiver and allows withdrawals of the related service credit. All communications from qualified Canadian governmental entities and their retirement systems must be certified in English translation. The contributions required under this subrule shall be in an amount equal to the actuarial cost of the service purchase as determined under 21.24(2)*"f."*

21.24(14) *Patient advocate service purchases.*

a. Current and former patient advocates employed under Iowa Code section 229.19 shall be eligible for a wage adjustment under Iowa Code section 97B.9(4) as amended by 2000 Iowa Acts, Senate File 2411, section 23, for the four quarters preceding the date that the patient advocate began IPERS coverage, or effective July 1, 2000, whichever is earlier. Additional service credit for employment as a patient advocate may be purchased as follows:

(1) For purchases completed prior to July 1, 2002, the cost for each quarter will be calculated using the methods set forth in paragraphs 21.24(2)*"b"* through *"e."*

(2) For purchases completed on or after July 1, 2002, the cost for each quarter will be calculated using the methods set forth in paragraph 21.24(2)*"f."*

b. Current patient advocates, former patient advocates who are vested or retired, and former patient advocates who have four quarters of wages on file as the result of wage adjustments shall qualify for service purchases under this subrule.

21.24(15) *IRC Section 415(n) compliance.* Effective for service purchases made on or after January 1, 1998, service purchases made under this rule and other posttax contributions shall not exceed $30,000 per calendar year. In addition, the amounts contributed for service purchases under this rule shall not exceed the amount required to purchase the service according to the current cost schedules. In implementing these and the other requirements of IRC Section 415(n), IPERS shall use the following procedures.

a. If the member's total benefit at retirement passes the fully reduced IRC Section 415(b) dollar limit test, IPERS shall pay the total benefit.

b. If the member's total benefit at retirement fails the fully reduced IRC Section 415(b) dollar limit test, and the member made one or more service purchases, IPERS shall perform the applicable IRC Section 415 tests, with adjustments for posttax service purchases and other posttax contributions, and pay excess amounts, if any, under a qualified benefits arrangement authorized under Iowa Code section 97B.49I.

c. IPERS shall not permit the purchase of nonqualified service, as defined under IRC Section 415(n), unless such service is specifically authorized by the Iowa legislature. If so authorized, a member must have five years of existing service to make such a purchase, and the quarters of service purchased cannot exceed 20.

d. The limitations of this rule shall not apply to buybacks of prior refunds. In addition, the $30,000 annual limit under this rule shall not apply to service purchases grandfathered under the provisions of the Iowa Code and Section 1526 of the Taxpayer Relief Act of 1997.

e. If IPERS adopts rules and procedures permitting service to be purchased on a pretax basis, the amounts contributed will not be combined with posttax service purchases and other posttax contributions in applying the foregoing procedures.

f. The provisions of this subrule shall apply to all vested members who have an account balance and retirees.

g. IPERS reserves the right to apply the limitations of IRC Section 415(n) on a case-by-case basis to ensure that such limits are not exceeded.

21.24(16) If a member is attempting to purchase service credit under this rule, and any particular subrule under this rule requires that the member must have four calendar quarters of wages on file as a precondition to making the purchase, and the member's regular job duties are performed in fewer than four calendar quarters each year, the four calendar quarter requirement shall be reduced to the number of calendar quarters regularly worked by the member.

This rule is intended to implement Iowa Code sections 97B.42, 97B.43, 97B.72A, 97B.73 as amended by 2000 Iowa Acts, Senate File 2411, section 68, 97B.74, 97B.75, 97B.80 and 2000 Iowa Acts, Senate File 2411, sections 70 and 71.

581—21.25(97B) South Africa restrictions. Rescinded IAB 7/5/95, effective 8/9/95.

581—21.26(97B) Garnishments and income withholding orders. For the limited purposes of this rule, the term "member" includes IPERS members, beneficiaries, contingent annuitants and any other third-party payees to whom IPERS is paying a monthly benefit or a lump sum distribution.

A member's right to any payment from IPERS is not transferable or assignable and is not subject to execution, levy, attachment, garnishment, or other legal process, including bankruptcy or insolvency law, except for the purpose of enforcing child, spousal, or medical support.

Only members receiving payment from IPERS, including monthly benefits and lump sum distributions, may be subject to garnishment, attachment, or execution against funds that are payable. Such garnishment, attachment, or execution is not valid and enforceable for members who have not applied for and been approved to receive funds from IPERS.

Upon receipt of an income withholding order issued by the Iowa department of human services or a court, IPERS shall send a copy of the withholding order to the member. If a garnishment has been issued by a court, the party pursuing the garnishment shall send a notice pursuant to Iowa law to the member against whom the garnishment is issued.

IPERS shall continue to withhold a portion of the member's monthly benefit as specified in the initial withholding order until instructed by the court or the Iowa department of human services issuing the order to amend or cease payment. IPERS shall continue to withhold a portion of the member's monthly benefit as specified in the garnishment until the garnishment expires or is released.

Funds withheld or garnished are taxable to the member. IPERS will assess a fee of $2 per payment in accordance with Iowa Code section 252D.18(1)*"b."* The fee will be deducted from the gross amount, less federal and state income tax, before a distribution is divided.

A garnishment, attachment or execution may not be levied upon funds which are already the subject of a levy, including a levy placed upon funds by the United States Internal Revenue Service, unless the requirements of 26 CFR Section 6334-1(a)(8) are met. Multiple garnishments, attachments and executions are allowed as long as the amount levied upon does not exceed the limitations prescribed in 15 U.S.C. Section 1673(b).

IPERS may release information relating to entitlement to funds to a court or to the Iowa department of human services prior to receipt of a valid garnishment, attachment, execution, or income withholding order when presented with a written request stating the information requested and reasons for the request. This request must be signed by a magistrate, judge, or child support recovery unit director or the director's designee, including an attorney representing the Iowa department of human services. In addition, IPERS may release information to the Iowa department of human services through automated matches.

This rule is intended to implement Iowa Code sections 97B.38 and 97B.39.

581—21.27(97B) Rollovers. If a member who is paid a lump sum distribution, or a beneficiary who is the member's spouse and is paid a lump sum death benefit which qualifies to be rolled over, requests that the taxable portion be rolled over to more than one IRA or other qualified plan, IPERS will assess a $5 administrative fee for each additional rollover beyond the first one. The fee will be deducted from the gross amount of each distribution, less federal and state income tax. All amounts that would otherwise be eligible for rollover and are paid in the same taxable year shall be aggregated to determine if a distribution equals or exceeds the $200 minimum rollover amount.

This rule is intended to implement Iowa Code sections 97B.38, 97B.48, 97B.48A, 97B.52, 97B.53, and 97B.53B.

g. A domestic relations order shall not become effective until it is approved by IPERS. If a member is receiving a retirement allowance at the time a domestic relations order is received by the system, the order shall be effective only with respect to payments made after the order is determined to be a qualified domestic relations order. If the member is not receiving a retirement allowance at the time a domestic relations order is received by IPERS and the member applies for a refund or monthly allowance, or dies, no distributions shall be made until the respective rights of the parties under the domestic relations order are determined by IPERS.

h. IPERS and its staff shall have no liability for making or withholding payments in accordance with the provisions of this rule.

i. Alternate payees must notify IPERS of any change in mailing address. IPERS shall contact the alternate payee in writing at the last-known mailing address on file with IPERS, notifying the alternate payee that an application for a distribution has been received with respect to the member and providing the alternate payee with an application to be completed and returned by the alternate payee. The written notice shall provide that if the alternate payee does not return said application to IPERS within 60 days after such written materials are mailed by IPERS, the amounts otherwise payable to the alternate payee shall be paid to the member or the member's beneficiary(ies) until a valid application is received, and IPERS shall have no liability to the alternate payee with respect to such amounts. IPERS has no duty or responsibility to search for alternate payees. If distributions have already begun at the time that an order determined by IPERS to be a qualified domestic relations order, the qualified domestic relations order shall be deemed to be the alternate payee's application to begin receiving his or her payments under the QDRO.

j. If an alternate payee's application is received less than two weeks before the member's first or next monthly payment is to be made, payments to the alternate payee shall begin the next following month.

k. For both lump sum and monthly payments, the alternate payee's tax withholding and rollover (if eligible) elections must be received not less than two weeks in advance of the alternate payee's first payment, or IPERS will use the applicable default elections.

This rule is intended to implement Iowa Code sections 97B.4, 97B.15 and 97B.39.

581—21.30(97B) Favorable experience dividend under Iowa Code section 97B.49F(2).

21.30(1) *Allocation of favorable experience.* The department shall annually allocate the system's favorable actuarial experience, if any, between the reserve account created under Iowa Code section 97B.49F(2) and the remainder of the retirement fund according to the following schedule.

Years to Amortize Unfunded Liability	Percentage to FED Reserve
Greater than 0 but less than or equal to 3	50%
Greater than 3 but less than or equal to 6	35%
Greater than 6 but less than or equal to 9	25%
Greater than 9 but less than or equal to 12	15%
Greater than 12 but less than or equal to 15	5%
Greater than 15	0%

The portion of the favorable actuarial experience that is not allocated to the FED reserve as provided above will be retained and used by the system to pay down its unfunded actuarial accrued liability, except as otherwise required by Iowa Code section 97B.49F(2)*"c."*

21.30(2) *Determination of applicable percentage.* The department shall have sole discretion to determine the applicable percentages that will be used in calculating favorable experience dividends payable under this rule, if any, subject to the actuary's certification that the resulting favorable experience dividends meet the requirements of Iowa Code section 97B.49F(2) and this rule.

a. The department's annual applicable percentage target for calculating dividends under Iowa Code section 97B.49F(2) shall be equal to the applicable percentage used in calculating dividends payable to retirees under Iowa Code section 97B.49F(1). Notwithstanding the foregoing, the department may set a greater or lesser applicable percentage for calculating dividends under this rule depending on the funding adequacy of the reserve account. In no event shall the applicable percentage exceed 3 percent.

b. In determining the annual applicable percentage, the department shall consider, but not be limited to, the value of the reserve account, distributions made from the reserve account in previous years, and the likelihood of future credits to and distributions from the reserve account. The department shall make its annual applicable percentage decisions using at least a rolling five-year period.

c. If for any year the department cannot afford an applicable percentage equal to that payable to retirees under Iowa Code section 97B.49F(1), the department may use applicable percentages in succeeding years that are higher than those used in calculating dividends for retirees under Iowa Code section 97B.49F(1) (but not in excess of 3 percent).

d. An applicable percentage in excess of the applicable percentage declared under Iowa Code section 97B.49F(1) made for catch-up purposes shall not reduce the funding of the reserve account below the amount the system's actuary determines is necessary to pay the maximum favorable experience dividend for each of the next five years, based on reasonable actuarial assumptions.

21.30(3) *Calculation of FED for individual members and beneficiaries.* A member must be retired for one full year to qualify for a favorable experience dividend. In determining whether a member has been retired one full year, the department shall count the member's first month of entitlement as the first month of the one-year period. The month in which the favorable experience dividend is payable shall be included in determining whether a member meets the eligibility requirements.

An eligible member's favorable experience dividend shall be calculated by multiplying the retirement allowance payable to the retiree, beneficiary, or contingent annuitant for the previous December, or such other month as determined by the department, by 12, and then multiplying that amount by the number of complete years the member has been retired or would have been retired if living on the date the dividend is payable, and by the applicable percentage set by the department. The number of complete years the member has been retired shall be determined by rounding down to the nearest whole year.

21.30(4) *FED for eligible members and beneficiaries who die before the January distribution date.* If a member or beneficiary receiving monthly payments would have been eligible for a FED distribution in the following January but dies prior to the January distribution date, IPERS will pay a FED to the member's or beneficiary's account for the calendar year in which the death occurred. The FED shall be calculated using the monthly payments received in the calendar year the death occurred. A lump sum death benefit shall not constitute a monthly payment for purposes of determining FED eligibility or in making FED calculations.

The FED percentage applied to the monthly payments received in the calendar year of death shall be the most recently declared FED percentage in effect at the time of the FED payment to the member or beneficiary. This subrule shall not be construed to permit a FED distribution to a member where the total monthly benefits received by the member, counting the month of death, is less than 12, even if a period of 12 months has elapsed between the first payment of monthly benefits to the member and the January distribution date.

Notwithstanding the foregoing, if IPERS determines in January of a given year that, based on reasonable actuarial assumptions, there is a reasonable likelihood that a FED will not be declared for the next following January, IPERS may defer paying FED distributions under this subrule until the determination is made. If IPERS subsequently determines that no FED will be declared for a given year, no FED will be payable to persons whose death occurs during the applicable calendar year.

Effective July 1, 2000, a retiree or beneficiary eligible for a FED payment must, in addition to all other applicable requirements, be living on January 1 in order to receive a FED payment otherwise payable in that January.

21.30(5) No transfer of favorable experience to the FED reserve fund shall exceed the amount that would extend IPERS' unfunded liability amortization period to more than the applicable limit then in effect under the funding policy adopted by IPERS.

This rule is intended to implement Iowa Code section 97B.49F(2) as amended by 2000 Iowa Acts, Senate File 2411, sections 43 and 45.

581—21.31(78GA,SF2411) Disability claim process under 2000 Iowa Acts, Senate File 2411, section 51. Except as otherwise indicated, this rule shall apply only to disability claims initiated under 2000 Iowa Acts, Senate File 2411, section 51. Except as otherwise indicated, disability claims under Iowa Code section 97B.50(2) shall be administered under rule 581—21.22(97B).

21.31(1) *Initiation of disability claim.* The disability claim process shall originate as an application to the system by the member. The application shall be forwarded to the system's designated retirement benefits officer. An application shall be sent upon request. The application consists of the following sections which must be completed and returned to the system's designated retirement benefits officer:

1. General applicant information.
2. Applicant's statement.
3. Employer's statement.
4. Member's assigned duties.
5. Disability/injury reports.
6. Medical information release.

21.31(2) *Preliminary processing.* Completed forms shall be returned to the disability retirement benefits officer. If the forms are not complete, they will be returned for completion. The application package shall contain copies of all relevant medical records and the names, addresses, and telephone numbers of all relevant physicians. If medical records are not included, the designated retirement benefits officer shall contact the listed physicians for copies of the files on the individual and shall request that any applicable files be sent to the medical board. In addition, IPERS may request workers' compensation records, social security records and such other official records as are deemed necessary. The application, including copies of the medical information, shall be forwarded to the medical board for review. All medical records that will be part of a member's permanent file shall be kept in locked locations separate from the member's other retirement records.

21.31(3) *Scheduling of appointments.* Upon receipt and forwarding of the application and sufficient medical records to the medical board, the disability retirement benefits officer shall establish an appointment for the applicant to be seen by the medical board in Iowa City. The member shall be notified by telephone and in writing of the appointment, and given general instructions about where to go for the examinations. The appointment for the examinations shall be no later than 60 days after the completed application, including sufficient medical records, is provided. All examinations must be scheduled and completed on the same date. The member shall also be notified about the procedures to follow for reimbursement of travel expenses and lodging. Fees for physical examinations and medical records costs shall be paid directly by IPERS pursuant to its contractual arrangements with the medical providers required to implement 2000 Iowa Acts, Senate File 2411, section 51.

21.31(4) *Medical board examinations.* The medical board, consisting of three physicians from the University of Iowa occupational medicine clinic and other departments as required, shall examine the member and perform the relevant tests and examinations pertaining to the difficulty the member is having.

The medical board shall submit a letter of recommendation to the system, based on its findings and the job duties supplied in the member's application, whether or not the member is mentally or physically incapacitated from the further performance of the member's duties and whether or not the incapacity is likely to be permanent. "Permanent" means that the mental or physical incapacity is reasonably expected to last more than one year. The medical board's letter of recommendation shall include a recommended schedule for reexaminations to determine the continued existence of the disability in question.

IPERS shall not be liable for any diagnostic testing procedures performed in accordance with 2000 Iowa Acts, Senate File 2411, section 51, and this rule which are alleged to have resulted in injury to the members being examined.

The medical board shall furnish its determination, test results, and supporting notes to the system no later than ten working days after the date of the examination.

The medical board shall not be required to have regular meetings, but shall be required to meet with IPERS' representatives at reasonable intervals to discuss the implementation of the program and performance review.

21.31(5) *Member and employer comments.* Upon receipt by the system, the medical board's determination regarding the existence or nonexistence of a permanent disability shall be distributed to the member and to the employer for review. The member and the employer may forward to the system written statements pertaining to the medical board's findings within ten days of transmittal. If relevant medical information not considered in materials previously forwarded to the medical board is contained within such written statements, the system shall submit such information to the medical board for review and comment.

21.31(6) *Fast-track review.* IPERS' disability retirement benefits officer may refer any case to IPERS' chief benefits officer for fast-track review. The chief benefits officer may, based upon a review of the member's application and medical records, determine that the medical board be permitted to make its recommendations based solely upon a review of the application and medical records, without requiring the member to submit to additional medical examinations by, or coordinated through, the medical board.

21.31(7) *Initial administrative determination.* The medical board's letter of recommendation, test results, and supporting notes, and the member's file shall be forwarded to IPERS. Except as otherwise requested by IPERS, the medical board shall forward hospital discharge summary reports rather than the entire set of hospital records. The complete file shall be reviewed by the system's disability retirement benefits officer, who shall, in consultation with the system's legal counsel, make the initial disability determination. Written notification of the initial disability determination shall be sent to the member and the member's employer within 14 days after a complete file has been returned to IPERS for the initial disability determination.

21.31(8) *General benefits provisions.* If an initial disability determination is favorable, benefits shall begin as of the date of the initial disability determination or, if earlier, the member's last day on the payroll, but no more than six months of retroactive benefits are payable. "Last day on the payroll" shall include any form of authorized leave time, whether paid or unpaid. If a member receives short-term disability benefits from the employer while awaiting a disability determination hereunder, disability benefits will accrue from the date the member's short-term disability payments are discontinued. If an initial favorable determination is appealed, the member shall continue to receive payments pending the outcome of the appeal.

Any member who is awarded disability benefits under 2000 Iowa Acts, Senate File 2411, section 51, and this rule shall be eligible to elect any of the benefit options available under Iowa Code section 97B.51 as amended by 2000 Iowa Acts, Senate File 2411, section 52. All such options shall be the actuarial equivalent of the lifetime monthly benefit provided in 2000 Iowa Acts, Senate File 2411, section 51, subsections 2 and 3.

The disability benefits established under this subrule shall be eligible for the favorable experience dividends payable under Iowa Code section 97B.49F(2).

If the award of disability benefits is overturned upon appeal, the member may be required to repay the amount already received or, upon retirement, have payments suspended or reduced until the appropriate amount is recovered.

21.31(9) *In-service disability determinations.* Subject to the presumptions contained in 2000 Iowa Acts, Senate File 2411, section 51, in determining whether a member's mental or physical incapacity arises in the actual performance of duty, "duty" shall mean:

a. For special service members other than firefighters, any action that the member, in the member's capacity as a law enforcement officer:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs in the course of controlling or reducing crime or enforcing the criminal law; or

b. For firefighters, any action that the member, in the member's capacity as a firefighter:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs while on the scene of an emergency run (including false alarms) or on the way to or from the scene.

21.31(10) *Appeal rights.* The member or the employer, or both, may appeal IPERS' initial disability determination. Such appeals must be in writing and submitted to IPERS' chief benefits officer within 30 days after the date of the system's initial notification letter. The system shall conduct an internal review of the initial disability determination, and the chief benefits officer shall notify the party who filed the appeal in writing of IPERS' final disability determination with respect to the appeal. The chief benefits officer may appoint a review committee to make nonbinding recommendations on such appeals. The disability retirement benefits officer, if named to the review committee, shall not vote on any such recommendations, nor shall any members of IPERS' legal staff participate in any capacity other than a nonvoting capacity. Further appeals shall follow the procedures set forth in rule 581—21.9(97B).

21.31(11) *Notice of abuse of disability benefits.* The system has the obligation and full authority to investigate allegations of abuse of disability benefits. The scope of the investigation to be conducted shall be determined by the system, and may include the ordering of a sub rosa investigation of a disability recipient to verify the facts relating to an alleged abuse. A sub rosa investigation shall only be considered upon receipt and evaluation of an acceptable notice of abuse. The notification must be in writing and include:

a. The informant's name, address, telephone number, and relationship to the disability recipient; and

b. A statement pertaining to the circumstances that prompted the notification, such as activities which the informant believes are inconsistent with the alleged disability.

c. Anonymous calls shall not constitute acceptable notification.

IPERS may employ such investigators and other personnel as may be deemed necessary, in IPERS' sole discretion, to carry out this function. IPERS may also, in its sole discretion, decline to carry out such investigations if more than five years have elapsed since the date of the disability determination.

21.31(12) *Qualification for social security or railroad retirement disability benefits.* Upon qualifying for social security or railroad retirement disability benefits, a member may contact the system to have the member's disability benefits calculated under Iowa Code section 97B.50(2) as amended by 2000 Iowa Acts, Senate File 2411, section 49. The election to stop having benefits calculated under 2000 Iowa Acts, Senate File 2411, section 51, and to start having benefits calculated under Iowa Code section 97B.50(2) as amended by 2000 Iowa Acts, Senate File 2411, section 49, must be in writing on forms developed or approved by the system, is irrevocable, and must be made within 60 days after the member receives written notification of eligibility for disability benefits from social security.

21.31(13) *Reemployment/income monitoring.* A member who retires under 2000 Iowa Acts, Senate File 2411, section 51, and this rule shall be required to supply a copy of a complete set of the member's state and federal income tax returns, including all supporting schedules, by June 30 of each calendar year. IPERS may suspend the benefits of any such member if such records are not timely provided.

Only wages and self-employment income shall be counted in determining a member's reemployment comparison amount, as adjusted for health care coverage for the member and the member's dependents.

For purposes of calculating the income offsets required under 2000 Iowa Acts, Senate File 2411, section 51, IPERS shall convert any lump sum workers' compensation award to an actuarial equivalent, as determined by IPERS' actuary.

This rule is intended to implement 2000 Iowa Acts, Senate File 2411, section 51.

581—21.32(97B) Qualified benefits arrangement. This rule establishes a separate unfunded qualified benefits arrangement (QBA) as provided for in Iowa Code section 97B.49I. This arrangement is established for the sole purpose of enabling IPERS to continue to apply the same formula for determining benefits payable to all employees covered by IPERS, including those whose benefits are limited by Section 415 of the Internal Revenue Code.

21.32(1) IPERS shall administer the QBA. IPERS has full discretionary authority to determine all questions arising in connection with the QBA, including its interpretation and any factual questions arising under the QBA. Further, IPERS has full authority to make modifications to the benefits payable under the QBA as may be necessary to maintain its qualification under Section 415(m) of the Internal Revenue Code.

21.32(2) All members, retired members, and beneficiaries of IPERS are eligible to participate in the QBA if their benefits would exceed the limitations imposed by Section 415 of the Internal Revenue Code. Participation is determined for each plan year, and participation shall cease for any plan year in which the benefit of a retiree or beneficiary is not limited by Section 415 of the Internal Revenue Code.

21.32(3) On and after the effective date of the QBA, IPERS shall pay to each eligible retiree and beneficiary a supplemental pension benefit equal to the difference between the retiree's or beneficiary's monthly benefit otherwise payable from IPERS prior to any reduction or limitation because of Section 415 of the Internal Revenue Code and the actual monthly benefit payable from IPERS as limited by Section 415. IPERS shall compute and pay the supplemental pension benefits in the same form, at the same time, and to the same persons as such benefits would have otherwise been paid as a monthly pension under IPERS except for said Section 415 limitations.

21.32(4) IPERS may consult its actuary to determine the amount of benefits that cannot be provided under IPERS because of the limitations of Section 415 of the Internal Revenue Code, and the amount of contributions that must be made to the QBA rather than to IPERS. Fees for the actuary's service shall be paid by the applicable employers.

21.32(5) Contributions shall not be accumulated under this QBA to pay future supplemental pension benefits. Instead, each payment of contributions by the applicable employer that would otherwise be made to IPERS shall be reduced by the amount necessary to pay supplemental pension benefits and administrative expenses of the QBA. The employer shall pay to this QBA the contributions necessary to pay the required supplemental pension payments, and these contributions will be deposited in a separate fund which is a portion of the qualified plan established and administered by IPERS. This fund is intended to be exempt from federal income tax under Sections 115 and 415(m) of the Internal Revenue Code. IPERS shall pay the required supplemental pension benefits to the member out of the employer contributions so transferred. The employer contributions otherwise required under the terms of Iowa Code sections 97B.11, 97B.49B and 97B.49C shall be divided into those contributions required to pay supplemental pension benefits hereunder, and those contributions paid into and accumulated in the IPERS trust fund to pay the maximum benefits permitted under Iowa Code chapter 97B. Employer contributions made to provide supplemental pension benefits shall not be commingled with the IPERS trust fund. The supplemental pension benefit liability shall be funded on a plan-year-to-plan-year basis. Any assets of the separate QBA fund not used for paying benefits for a current plan year shall be used, as determined by IPERS, for the payment of administrative expenses of the QBA for the plan year.

21.32(6) A member cannot elect to defer the receipt of all or any part of the payments due under this QBA.

21.32(7) Payments under this rule are exempt from garnishment, assignment, attachment, alienation, judgments, and other legal processes to the same extent as provided under Iowa Code section 97B.39.

21.32(8) Nothing herein shall be construed as providing for assets to be held in trust or escrow or any form of asset segregation for members, retirees, or beneficiaries. To the extent any person acquires the right to receive benefits under this QBA, the right shall be no greater than the right of any unsecured general creditor of the state of Iowa.

21.32(9) This QBA is a portion of a governmental plan as defined in Section 414(d) of the Internal Revenue Code, is intended to meet the requirements of Internal Revenue Code Sections 115 and 415(m), and shall be so interpreted and administered.

21.32(10) Amounts deducted from employer contributions and deposited in the separate QBA fund shall not reduce the amounts that are to be credited to employer contribution accounts under Iowa Code sections 97B.11, 97B.49B and 97B.49C.

This rule is intended to implement Iowa Code section 97B.49I.

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7.5(2) The local or joint commission shall determine the personnel policies of the agency to include holidays, rate of pay, sick leave, vacation, and health benefits. The local commission may adopt existing county or city policies in lieu of writing their own policies.

605—7.6(29C) Damage assessment and financial assistance for disaster recovery. Disaster-related expenditures and damages incurred by local governments, private nonprofit entities, individuals, and businesses may be reimbursable and covered under certain state and federal disaster assistance programs. Preliminary damage assessments shall be provided to the emergency management division prior to the governor's making a determination that the magnitude and impact are sufficient to warrant a request for a presidential disaster declaration.

7.6(1) *Local preliminary damage assessment and impact statement.* The county emergency management coordinator shall be responsible for the coordination and collection of damage assessment and impact statement information immediately following a disaster that affects the county or any municipality within the county.

7.6(2) *Damage assessment guidance and forms to be provided.* The state emergency management division will provide guidance regarding the methodologies to be used in collecting damage assessment and impact statement information and shall provide the forms and format by which this information shall be recorded.

7.6(3) *Joint preliminary damage assessment.* Once the governor has determined that a request for a presidential disaster declaration is appropriate, joint preliminary damage assessment teams, consisting of local, state, and federal inspectors, will assess the uninsured damages and costs incurred or to be incurred in responding to and recovering from the disaster. All affected city, municipality, or county governments shall be required to provide assistance to the joint preliminary damage assessment teams for conducting damage assessments. The jurisdiction may be required to develop maps to show the damaged areas and to compile lists of names and telephone numbers of individuals, businesses, private nonprofit entities, and governmental agencies sustaining disaster response and recovery costs or damages. This joint preliminary damage assessment may be required before the request for presidential declaration is formally transmitted to the Federal Emergency Management Agency.

7.6(4) *Public assistance and hazard mitigation briefing.* In the event that a presidential disaster declaration is received, affected jurisdictions and eligible private nonprofit entities should be prepared to attend a public assistance and hazard mitigation briefing to acquire the information and documents necessary to make their formal applications for public and hazard mitigation assistance. Failure to comply with the deadlines for making application for public and mitigation assistance as established in 44 CFR Part 206 and the Stafford Act (PL 923-288) may jeopardize or eliminate the jurisdiction's or private nonprofit entity's ability to receive assistance.

7.6(5) *Forfeiture of assistance funding.* Failure to provide timely and accurate damage assessment and impact statement information may jeopardize or eliminate an applicant's ability to receive federal and state disaster assistance funds that may otherwise be available.

State participation in funding of disaster financial assistance in a presidentially declared disaster shall be contingent upon the local or joint emergency management commission's having on file a state-approved, comprehensive, countywide emergency operations plan which meets the standards as provided in subrule 7.3(4), paragraph *"d."*

605—7.7(29C) Emergency management performance grant program. Emergency management is a joint responsibility of the federal government, the states, and their political subdivisions. Emergency management means all those activities and measures designed or undertaken to mitigate against, prepare for, respond to, or recover from the effects of a human-caused, technological, or natural hazard. The purpose of the emergency management performance grant program is to provide the necessary assistance to local governments to ensure that a comprehensive emergency preparedness system exists for all hazards.

7.7(1) *Eligibility.* Local or joint emergency management commissions may be eligible for funding under the state and emergency management performance grant program by meeting the requirements, conditions, duties and responsibilities for emergency management commissions and county emergency management coordinators established in rules 7.3(29C) and 7.4(29C). In addition, the local commission shall ensure that the coordinator works an average of 20 hours per week or more toward the emergency management effort. Joint commissions shall ensure that the coordinator works an average of 40 hours per week toward the emergency management effort.

7.7(2) *Application for funding.* Local or joint commissions may apply for funding under the emergency management performance grant program by entering into an agreement with the division and by completing the necessary application and forms, as published and distributed yearly to each commission by the division.

7.7(3) *Allocation and distribution of funds.* The emergency management division shall allocate funds to eligible local or joint commissions within 45 days of receipt of notice from the Federal Emergency Management Agency that such funds are available. The division shall use a formula for the allocation of funds based upon the number of eligible applicants, the coordinator's salary and benefits and an equal distribution of remaining funds, not to exceed an individual applicant's request. Funds will be reimbursed to local and joint commissions on a federal fiscal year, quarterly basis; and such reimbursement will be based on eligible claims made against the local or joint commission's allocation. In no case will the allocation or reimbursement of funds be greater than one-half of the total cost of eligible emergency management related expenses.

7.7(4) *Compliance.* The administrator may withhold or recover emergency management performance grant funds from any local or joint commission for its failure or its coordinator's failure to meet any of the following conditions:

a. Appoint a qualified coordinator.

b. Comply with continuing education requirements.

c. Adopt a comprehensive countywide emergency operations plan that meets current standards.

d. Determine the mission of its agency.

e. Show continuing progress in fulfilling the commission's duties and obligations.

f. Conduct commission business according to the guidelines and rules established in this chapter.

g. Enter into and file a cooperative agreement with the division by the stipulated filing date.

h. Abide by state and federal regulations governing the proper disbursement and accountability for federal funds, equal employment opportunity and merit system standards.

i. Accomplish work specified in one or more program areas, as agreed upon in the cooperative agreement, or applicable state or federal rule or statute.

j. Provide the required matching financial contribution.

k. Expend funds for authorized purposes or in accordance with applicable laws, regulations, terms and conditions.

l. Respond to, or cooperate with, state efforts to determine the extent and nature of compliance with the cooperative agreement.

7.7(5) *Serious nonperformance problems.* If a local or joint commission cannot demonstrate achievement of agreed-upon work products, the division is empowered to withhold reimbursement or to recover funds from the local or joint commission. Corrective action procedures are designed to focus the commission's attention on nonperformance problems and to bring about compliance with the cooperative agreement. Corrective action procedures, which could lead to sanction, may be enacted as soon as the administrator becomes aware of serious nonperformance or noncompliance. This realization may arise from staff visits or other contacts with the local agency or commission, from indications in the commission's or coordinator's quarterly report that indicate a significant shortfall from planned accomplishments, or from the commission's or coordinator's failure to report. Financial sanctions are to be applied only after corrective action remedies fail to result in accomplishment of agreed-upon work product.

7.7(6) *Corrective actions.*

a. Informal corrective action. As a first and basic step to correcting nonperformance, a designated member of the state emergency management division staff will visit, call or write the local coordinator to determine the reason for nonperformance and seek an agreeable resolution.

b. Formal corrective action. On those occasions when there is considerable discrepancy between agreed-upon and actual performance and response to informal corrective action is not sufficient or agreeable, the division will take the following steps:

(1) Emergency management staff will review the scope of work, as agreed to in the cooperative agreement, to determine the extent of nonperformance. To focus attention on the total nonperformance issue, all instances of nonperformance will be addressed together in a single correspondence to the local or joint commission.

(2) The administrator will prepare a letter to the local or joint commission which will contain, at a minimum, the following information:

1. The reasons why the division believes the local or joint commission may be in noncompliance, including the specified provisions in question.
2. A description of the efforts made by the division to resolve the matter and the reasons these efforts were unsuccessful.
3. A declaration of the local or joint commission's commitment to accomplishing the work agreed upon and specified in the comprehensive cooperative agreement and its importance to the emergency management capability of the local jurisdiction.
4. A description of the exact actions or alternative actions required of the local or joint commission to bring the problem to an agreed resolution.
5. A statement that this letter constitutes the final no-penalty effort to achieve a resolution and that financial sanctions provided for in these rules will be undertaken if a satisfactory response is not received by the division within 30 days.

7.7(7) *Financial sanctions.* If the corrective actions heretofore described fail to produce a satisfactory resolution to cases of serious nonperformance, the administrator may invoke the following financial sanction procedures:

a. Send a "Notice of Intention to Withhold Payment" to the chairperson of the local or joint commission. This notice shall also contain notice of a reasonable time and place for a hearing, should the local or joint commission request a hearing before the administrator.

b. Any request by a local or joint commission for a hearing must be made in writing, to the division, within 15 days of receipt of the notice of intention to withhold payment.

c. Any hearing under the notice of intention to withhold payment shall be held before the administrator. However, the administrator may designate an administrative law judge to take evidence and certify to the administrator the entire record, including findings and recommended actions.

d. The local or joint commission shall be given full opportunity to present its position orally and in writing.

e. If, after a hearing, the administrator finds sufficient evidence that the local or joint commission has violated established rules and regulations or the terms and conditions of the cooperative agreement, the administrator may withhold such contributions and payments as may be considered advisable, until the failure to expend funds in accordance with said rules, regulations, terms and conditions has been corrected or the administrator is satisfied that there will no longer be any such failure.

f. If upon the expiration of the 15-day period stated for a hearing, a hearing has not been requested, the administrator may issue the findings and take appropriate action as described in the preceding paragraph.

g. If the administrator finds there is serious nonperformance by the commission or its coordinator and issues an order to withhold payments to the local or joint commission as described in this rule, the commission shall not receive funds under the emergency management performance grant program for the remainder of the federal fiscal year in which the order is issued and one additional year or until such time that all issues of nonperformance have been agreeably addressed by the division and the commission.

h. Any emergency management perforce grant program funds withheld or recovered by the division as a result of this process shall be reallocated at the end of the federal fiscal year to the remaining participating counties.

These rules are intended to implement Iowa Code sections 29C.6 and 29C.8.

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CHAPTER 70
LEAD PROFESSIONAL CERTIFICATION

641—70.1(135) Applicability. Prior to March 1, 2000, this chapter applies to all persons who are certified lead professionals in Iowa. Beginning March 1, 2000, this chapter applies to all persons who are lead professionals in Iowa. While this chapter requires lead professionals to be certified and establishes specific requirements for how to perform lead-based paint activities if a property owner, manager, or occupant chooses to undertake them, nothing in this chapter requires a property owner, manager, or occupant to undertake any particular lead-based paint activity.

641—70.2(135) Definitions.

"Adequate quality control" means a plan or design which ensures the authenticity, integrity, and accuracy of samples, including dust, soil, and paint chip or paint film samples. Adequate quality control also includes provisions for representative sampling.

"Approved course" means a course that has been approved by the department for the training of lead professionals.

"Certified elevated blood lead (EBL) inspection agency" means an agency that has met the requirements of 641—70.5(135) and that has been certified by the department.

"Certified elevated blood lead (EBL) inspector/risk assessor" means a person who has met the requirements of 641—70.5(135) for certification or interim certification and who has been certified by the department.

"Certified firm" means a firm that has met the requirements of 641—70.5(135) for certification and has been certified by the department.

"Certified lead abatement contractor" means a person who has met the requirements of 641—70.5(135) for certification or interim certification and who has been certified by the department.

"Certified lead abatement worker" means a person who has met the requirements of 641—70.5(135) and who has been certified by the department.

"Certified lead inspector/risk assessor" means a person who has met the requirements of 641—70.5(135) for certification or interim certification and who has been certified by the department.

"Certified lead professional" means a person who has been certified by the department as a lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, lead abatement contractor, lead abatement worker, project designer, or visual risk assessor.

"Certified project designer" means a person who has met the requirements of 641—70.5(135) for certification or interim certification and who has been certified by the department.

"Certified visual risk assessor" means a person who has met the requirements of 641—70.5(135) and who has been certified by the department.

"Child-occupied facility" means a building, or portion of a building, constructed prior to 1978, visited by the same child under the age of six years, on at least two different days within any week (Sunday through Saturday period, provided that each day's visit lasts at least three hours and the combined weekly visits last at least six hours). Child-occupied facilities may include, but are not limited to, day-care centers, preschools and kindergarten classrooms.

"Clearance levels" means values that indicate the maximum amount of lead permitted in dust on a surface following completion of an abatement activity. These values are 100 micrograms per square foot on floors, 500 micrograms per square foot on window sills, and 800 micrograms per square foot on window troughs.

"Clearance testing" means an activity conducted following interim controls, lead abatement, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation to determine that the hazard reduction activities are complete and that no lead-contaminated soil or lead-contaminated dust exists in the dwelling unit or worksite. Clearance testing includes a visual assessment, the collection and analysis of environmental samples, the interpretation of sampling results, and the preparation of a report.

"Common area" means a portion of the building that is generally accessible to all occupants. This includes, but is not limited to, hallways, stairways, laundry and recreational rooms, playgrounds, community centers, garages, and boundary fences.

"Component" or *"building component"* means specific design or structural elements or fixtures of a building, residential dwelling, or child-occupied facility that are distinguished from each other by form, function, and location. These include, but are not limited to, interior components such as ceilings, crown moldings, walls, chair rails, doors, door trim, floors, fireplaces, radiators and other heating units, shelves, shelf supports, stair treads, stair risers, stair stringers, newel posts, railing caps, balustrades, windows and trim (including sashes, window heads, jambs, sills or stools and troughs), built-in cabinets, columns, beams, bathroom vanities, countertops, and air conditioners; and exterior components such as painted roofing, chimneys, flashing, gutters and downspouts, ceilings, soffits, fascias, rake boards, cornerboards, bulkheads, doors and door trim, fences, floors, joists, latticework, railings and railing caps, siding, handrails, stair risers and treads, stair stringers, columns, balustrades, windowsills or stools and troughs, casings, sashes and wells, and air conditioners.

"Composite sample" means the collection of more than one sample of the same medium (e.g., dust, soil, or paint) from the same type of surface (e.g., floor, interior windowsill, or window trough) such that multiple samples can be analyzed as a single sample.

"Containment" means a process to protect workers and the environment by controlling exposures to the lead-contaminated dust and debris created during an abatement.

"Course agenda" means an outline of the key topics to be covered during a training course, including the time allotted to teach each topic.

"Course test" means an evaluation of the overall effectiveness of the training which shall test the trainees' knowledge and retention of the topics covered during the course.

"Course test blueprint" means written documentation identifying the proportion of course test questions devoted to each major topic in the course curriculum.

"Department" means the Iowa department of public health.

"Deteriorated paint" means paint that is cracking, flaking, chipping, peeling, or otherwise separating from the substrate of a building component.

"Discipline" means one of the specific types or categories of lead-based paint activities identified in this chapter for which individuals may receive training from approved courses and become certified by the department. For example, "lead inspector/risk assessor" is a discipline.

"Distinct painting history" means the application history, as indicated by its visual appearance or a record of application, over time, of paint or other surface coatings to a component or room.

"Documented methodologies" means methods or protocols used to sample for the presence of lead in paint, dust, and soil.

"Elevated blood lead (EBL) child" means any child who has had one venous blood lead level greater than or equal to 20 micrograms per deciliter or at least two venous blood lead levels of 15 to 19 micrograms per deciliter.

"Elevated blood lead (EBL) inspection" means an inspection to determine the sources of lead exposure for an elevated blood lead (EBL) child and the provision within ten working days of a written report explaining the results of the investigation to the owner and occupant of the residential dwelling or child-occupied facility being inspected and to the parents of the elevated blood lead (EBL) child.

"Elevated blood lead (EBL) inspection agency" means an agency that employs or contracts with individuals who perform elevated blood lead (EBL) inspections. Elevated blood lead (EBL) inspection agencies may also employ or contract with individuals who perform other lead-based paint activities.

"Encapsulant" means a substance that forms a barrier between lead-based paint and the environment using a liquid-applied coating (with or without reinforcement materials) or an adhesively bonded coating material.

"Encapsulation" means the application of an encapsulant.

"Enclosure" means the use of rigid, durable construction materials that are mechanically fastened to the substrate in order to act as a barrier between lead-based paint and the environment.

"Firm" means a company, partnership, corporation, sole proprietorship, association, or other business entity, other than an elevated blood lead (EBL) inspection agency, that performs or offers to perform lead-based paint activities.

"Guest instructor" means an individual designated by the training program manager or principal instructor to provide instruction specific to the lecture, hands-on work activities, or work practice components of a course.

"Hands-on skills assessment" means an evaluation which tests the trainees' ability to satisfactorily perform the work practices and procedures identified in 641—70.6(135), as well as any other skill taught in a training course.

"Hazardous waste" means any waste as defined in 40 CFR 261.3.

"Interim controls" means a set of measures designed to temporarily reduce human exposure or likely exposure to lead-based paint hazards, including repairing deteriorated lead-based paint, specialized cleaning, maintenance, painting, temporary containment, ongoing monitoring of lead-based paint hazards or potential hazards, and the establishment and operation of management and resident education programs.

"Lead abatement" means any measure or set of measures designed to permanently eliminate lead-based paint hazards in a residential dwelling or child-occupied facility. Abatement includes, but is not limited to, (1) the removal of lead-based paint and lead-contaminated dust, the permanent enclosure or encapsulation of lead-based paint, the replacement of lead-painted surfaces or fixtures, and the removal or covering of lead-contaminated soil and (2) all preparation, cleanup, disposal, and postabatement clearance testing activities associated with such measures. Lead abatement specifically includes, but is not limited to, (1) projects for which there is a written contract or other documentation, which provides that an individual will be conducting activities in or to a residential dwelling or child-occupied facility that shall result in or are designed to permanently eliminate lead-based paint hazards, (2) projects resulting in the permanent elimination of lead-based paint hazards, (3) projects resulting in the permanent elimination of lead-based paint hazards that are conducted by firms or individuals who, through their company name or promotional literature, represent, advertise, or hold themselves out to be in the business of performing lead-based paint abatement, and (4) projects resulting in the permanent elimination of lead-based paint that are conducted in response to an abatement order. Abatement does not include renovation, remodeling, landscaping, or other activities, when such activities are not designed to permanently eliminate lead-based paint hazards, but, instead, are designed to repair, restore, or remodel a given structure or dwelling, even though these activities may incidentally result in a reduction or elimination of lead-based paint hazards. Furthermore, abatement does not include interim controls, operations and maintenance activities, or other measures and activities designed to temporarily, but not permanently, reduce lead-based paint hazards.

"Lead-based paint" means paint or other surface coatings that contain lead equal to or in excess of 1.0 milligram per square centimeter or more than 0.5 percent by weight.

"Lead-based paint activities" means, in the case of target housing and child-occupied facilities, lead inspection, elevated blood lead (EBL) inspection, lead hazard screen, risk assessment, lead abatement, visual risk assessment, clearance testing conducted after lead abatement, and clearance testing conducted after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR 35.1340.

"Lead-based paint hazard" means any condition that causes exposure to lead from lead-contaminated dust, lead-contaminated soil, or lead-based paint that is deteriorated or present in accessible surfaces, friction surfaces, and impact surfaces that would result in adverse human health effects.

"Lead-contaminated dust" means surface dust in residential dwellings or child-occupied facilities that contains in excess of 100 micrograms per square foot on floors, 500 micrograms per square foot on windowsills, and 800 micrograms per square foot on window troughs. For lead-based paint activities conducted pursuant to 24 CFR 35.1340, the standards specified by 24 CFR 35.1340 for lead-contaminated dust shall apply.

"Lead-contaminated soil" means bare soil on residential real property and on the property of a child-occupied facility that contains lead in excess of 400 parts per million for areas where child contact is likely and in excess of 2,000 parts per million if child contact is not likely.

"Lead hazard screen" means a limited risk assessment activity that involves limited paint and dust sampling.

"Lead inspection" means a surface-by-surface investigation to determine the presence of lead-based paint and a determination of the existence, nature, severity, and location of lead-based paint hazards in a residential dwelling or child-occupied facility and the provision of a written report explaining the results of the investigation and options for reducing lead-based paint hazards to the person requesting the lead inspection.

"Lead professional" means a person who conducts lead abatement, lead inspections, elevated blood lead (EBL) inspections, lead hazard screens, risk assessments, visual risk assessments, clearance testing after lead abatement, or clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR 35.1340.

"Living area" means any area of a residential dwelling used by at least one child under the age of six years, including, but not limited to, living rooms, kitchen areas, dens, playrooms, and children's bedrooms.

"Multifamily dwelling" means a structure that contains more than one separate residential dwelling unit, which is used or occupied, or intended to be used or occupied, in whole or in part, as the home or residence of one or more persons.

"Occupant protection plan" means a plan developed by a certified lead abatement contractor prior to the commencement of lead abatement in a residential dwelling or child-occupied facility that describes the measures and management procedures that will be taken during lead abatement to protect the building occupants from exposure to any lead-based paint hazards.

"Ongoing lead-based paint maintenance" means the maintenance of housing assisted by the U.S. Department of Housing and Urban Development pursuant to 24 CFR 35.1355.

"Paint stabilization" means repairing any physical defect in the substrate of a painted surface that is causing paint deterioration, removing loose paint and other material from the surface to be treated, and applying a new protective coating or paint.

"Permanently covered soil" means soil which has been separated from human contact by the placement of a barrier consisting of solid, relatively impermeable materials, such as pavement or concrete. Grass, mulch, and other landscaping materials are not considered permanent covering.

"Principal instructor" means the individual who has the primary responsibility for organizing and teaching a particular course.

"Recognized laboratory" means an environmental laboratory recognized by the U.S. Environmental Protection Agency pursuant to Section 405(b) of the federal Toxic Substance Control Act as capable of performing an analysis for lead compounds in paint, soil, and dust.

"Reduction" means measures designed to reduce or eliminate human exposure to lead-based paint hazards through methods including interim controls and abatement.

"Refresher training course" means a course taken by a certified lead professional to maintain certification in a particular discipline.

"Rehabilitation" means the improvement of an existing structure through alterations, incidental additions, or enhancements. Rehabilitation includes repairs necessary to correct the results of deferred maintenance, the replacement of principal fixtures and components, improvements to increase the efficient use of energy, and installation of security devices.

"Residential dwelling" means (1) a detached single-family dwelling unit, including the surrounding yard, attached structures such as porches and stoops, and detached buildings and structures including, but not limited to, garages, farm buildings, and fences, or (2) a single-family dwelling unit in a structure that contains more than one separate residential dwelling unit, which is used or occupied, or intended to be used or occupied, in whole or part, as the home or residence of one or more persons.

"Risk assessment" means an investigation to determine the existence, nature, severity, and location of lead-based paint hazards in a residential dwelling or child-occupied facility and the provision of a written report explaining the results of the investigation and options for reducing lead-based paint hazards to the person requesting the risk assessment.

"Standard treatments" means a series of hazard reduction measures designed to reduce all lead-based paint hazards in a dwelling unit without the benefit of a risk assessment or other evaluation.

"State certification examination" means a discipline-specific examination approved by the department to test the knowledge of a person who has completed an approved training course and is applying for certification in a particular discipline. The state certification examination may not be administered by the provider of an approved course.

"Target housing" means housing constructed prior to 1978 with the exception of housing for the elderly or for persons with disabilities and housing which does not contain a bedroom, unless at least one child under the age of six years resides or is expected to reside in the housing for the elderly or persons with disabilities or housing which does not contain a bedroom.

"Training hour" means at least 50 minutes of actual learning, including, but not limited to, time devoted to lecture, learning activities, small group activities, demonstrations, evaluations, or hands-on experience.

"Training manager" means the individual responsible for administering an approved course and monitoring the performance of principal instructors and guest instructors.

"Training program" means a person or organization sponsoring a lead professional training course.

"Visual inspection for clearance testing" means the visual examination of a residential dwelling or a child-occupied facility following lead abatement or following interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR 35.1340 to determine whether or not the lead abatement, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation has been successfully completed.

"Visual risk assessment" means a visual assessment to determine the presence of deteriorated paint or other potential sources of lead-based paint hazards in a residential dwelling or child-occupied facility and the provision of a written report explaining the results of the assessment to the person requesting the visual risk assessment.

"X-ray fluorescence analyzer (XRF)" means an instrument that determines lead concentrations in milligrams per square centimeter (mg/cm^2) using the principle of X-ray fluorescence.

641—70.3(135) Certification. Prior to March 1, 2000, lead professionals may be certified by the department. Beginning March 1, 2000, lead professionals and firms must be certified by the department in the appropriate discipline before they conduct lead abatement, clearance testing after lead abatement, lead inspections, elevated blood lead (EBL) inspections, lead hazard screens, risk assessments, and visual risk assessments, except persons who perform these activities within residential dwellings that they own, unless the residential dwelling is occupied by a person other than the owner or a member of the owner's immediate family while these activities are being performed. In addition, elevated blood lead (EBL) inspections shall be conducted only by certified elevated blood lead (EBL) inspector/risk assessors employed by or under contract with a certified elevated blood lead (EBL) inspection agency. Beginning September 15, 2000, clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, and rehabilitation pursuant to 24 CFR 35.1340 shall be conducted only by certified visual risk assessors, certified lead inspector/risk assessors, or certified elevated blood lead (EBL) inspectors. Lead professionals and firms shall not state that they have been certified by the state of Iowa unless they have met the requirements of rule 70.5(135) and been issued a certificate by the department. Prior to March 1, 2000, elevated blood lead (EBL) inspection agencies may be certified by the department. Beginning March 1, 2000, elevated blood lead (EBL) inspection agencies must be certified by the department. Elevated blood lead (EBL) inspection agencies shall not state that they have been certified by the state of Iowa unless they have met the requirements of rule 70.5(135) and been issued a certificate by the department.

641—70.4(135) Course approval and standards. Prior to March 1, 1999, lead professional training courses for initial certification and refresher training may be approved by the department. Beginning March 1, 1999, lead professional training courses for initial certification and refresher training must be approved by the department. Training programs shall not state that they have been approved by the state of Iowa unless they have met the requirements of rule 70.4(135) and been issued a letter of approval by the department.

70.4(1) Training courses shall meet the following requirements:

a. The training course shall employ a training manager who has the following qualifications:

(1) A bachelor's or graduate degree in building construction technology, engineering, industrial hygiene, safety, public health, or a related field; or two years of experience in managing a training program specializing in environmental hazards.

(2) Demonstrated experience, education, or training in lead professional activities, including lead inspection, lead abatement, painting, carpentry, renovation, remodeling, occupational safety and health, or industrial hygiene.

b. The training manager shall designate a qualified principal instructor for each course who has the following qualifications:

(1) Demonstrated experience, education, or training in teaching workers or adults.

(2) Certification as a lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, or lead abatement contractor.

(3) Demonstrated experience, education, or training in lead professional activities, including lead inspection, lead abatement, painting, carpentry, renovation, remodeling, occupational safety and health, or industrial hygiene.

c. The principal instructor shall be responsible for the organization of the course and oversight of the teaching of all course material. The training manager may designate guest instructors as needed to provide instruction specific to the lecture, hands-on activities, or work practice components of a course.

d. The training program shall ensure the availability of, and provide adequate facilities for, the delivery of the lecture, course test, hands-on training, and assessment activities. This includes providing training equipment that reflects current work practices and maintaining or updating the equipment as needed.

e. The training manager shall maintain the validity and integrity of the hands-on skills assessment to ensure that it accurately evaluates the trainees' performance of the work practices and procedures associated with the course topics contained in subrules 70.4(3) to 70.4(9).

f. The training manager shall maintain the validity and integrity of the course test to ensure that it accurately evaluates the trainees' knowledge and retention of the course topics.

g. The course test shall be developed in accordance with the test blueprint submitted with the course approval application.

h. The training program shall issue unique course completion certificates to each individual who passes the course. The course completion certificate shall include:

(1) The name and address of the individual and a unique identification number.

(2) The name of the particular course that the individual completed.

(3) Dates of course completion and test passage.

(4) The name, address, and telephone number of the training program.

i. The training manager shall develop and implement a quality control program. The plan shall be used to maintain and improve the quality of the training program over time. This plan shall contain at least the following elements:

(1) Procedures for periodic revision of training materials and the course test to reflect changes in regulations and recommended practices.

(2) Procedures for the training manager to conduct an annual review of the competency of the principal instructor.

j. The training program shall offer courses that teach the work practice standards for conducting lead-based paint activities contained in rule 70.6(135) and other standards developed by the department. These standards shall be taught in the appropriate courses to provide trainees with the knowledge needed to perform the lead-based paint activities they are responsible for conducting.

k. The training manager shall ensure that the training program complies at all times with all requirements in this rule.

l. The training manager shall allow the department to audit the training program to verify the contents of the application for approval and for reapproval.

m. The training program shall maintain, and make available to the department, upon request, the following records:

(1) All documents specified in paragraph 70.4(2)*"f."*

(2) Current curriculum/course materials and documents reflecting any changes made to these materials.

(3) The course test blueprint and the course test.

(4) Information regarding how the hands-on assessment is conducted including, but not limited to, who conducts the assessment, how the skills are graded, what facilities are used, and the pass/fail rate.

(5) The quality control plan as described in paragraph 70.4(1)*"i."*

(6) Results of the students' hands-on skills assessments and course tests and a record of each student's course completion certificate.

(7) Any other materials that have been submitted to the department as part of the program's application for approval.

n. The training program shall retain all required records at the address specified on the training program approval application for a minimum of six years.

o. The training program shall notify the department in writing within 30 days of changing the address specified on its training program approval application or transferring the records from that address.

70.4(2) If a training program desires approval of a course by the department, the training program shall apply to the department for approval of the course at least 90 days before the initial offering of the course. The application shall include:

a. Training program name, contact person, address, and telephone number.

b. Course dates and times.

c. Course location, including a description of the facilities and equipment to be used for lecture and hands-on training.

d. Course agenda, including approximate times allotted to each training segment.

e. A copy of each reference material, text, student and instructor manuals, and audio-visual material used in the course.

f. The name(s) and qualifications of the training manager, principal instructor(s), and guest instructor(s). The following documents shall be submitted as evidence that training managers and principal instructors have the education, work experience, training requirements, or demonstrated experience required by subrule 70.4(1):

(1) Official transcripts or diplomas as evidence of meeting the education requirements.

(2) Résumés, letters of reference, or documentation of work experience, as evidence of meeting the work experience requirements.

(3) Certificates from lead-specific training courses, as evidence of meeting the training requirements.

g. A copy of the course test blueprint.

h. A description of the activities and procedures that will be used for conducting the assessment of hands-on skills for each course.

i. Maximum class size.

j. A copy of the quality control plan for the course.

k. A nonrefundable fee of $200.

70.4(3) To be approved for the training of lead inspector/risk assessors prior to March 1, 1999, a course must be at least 24 training hours with a minimum of 8 hours devoted to hands-on training activities. Beginning March 1, 1999, a course must be at least 40 training hours with a minimum of 12 hours devoted to hands-on training activities. Lead inspector/risk assessor training courses shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of an inspector/risk assessor.

b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.

c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.

d. Lead-based paint inspection methods, including selection of rooms and components for sampling or testing to determine if a property is free of lead-based paint as specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development), and methods to determine if lead-based paint hazards are present in a property.*

e. Paint, dust, and soil sampling methodologies.*

f. Clearance standards and testing, including random sampling.*

g. Collection of background information to perform a risk assessment.

h. Sources of environmental lead contamination such as paint, surface dust and soil, and water.

i. Visual inspection to identify lead-based paint hazards.*

j. Lead hazard screen protocol.

k. Visual risk assessment protocol.

l. Sampling for other sources of lead exposure.*

m. Interpretation of lead-based paint and other lead sampling results, including all applicable federal, state, and local guidance or regulations pertaining to lead-based paint hazards.*

n. Development of hazard control options, the role of interim controls, and operations and maintenance activities to reduce lead-based paint hazards.

o. Approved methods for conducting lead-based paint abatement and interim controls.

p. Prohibited methods for conducting lead-based paint abatement and interim controls.

q. Interior dust abatement and cleanup.

r. Soil and exterior dust abatement and cleanup.

s. Preparation of the final inspection report.

t. Record keeping.

u. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(4) To be approved for the training of lead inspector/risk assessors who have already completed an approved visual risk assessor course, a course must be at least 20 training hours with a minimum of 8 hours devoted to hands-on training activities. The training course shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of a lead inspector/risk assessor.

b. Lead-based paint inspection methods, including selection of rooms and components for sampling or testing to determine if a property is free of lead-based paint as specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development), and methods to determine if lead-based paint hazards are present in a property.*

c. Collection of background information to perform a risk assessment.

d. Lead hazard screen protocol.

e. Visual risk assessment protocol.

f. Sampling for other sources of lead exposure.*

g. Interpretation of lead-based paint and other lead sampling results, including all applicable federal, state, and local guidance or regulations pertaining to lead-based paint hazards.*

h. Development of hazard control options, the role of interim controls, and operations and maintenance activities to reduce lead-based paint hazards.*

i. Preparation of the final inspection report.

j. Record keeping.

k. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(5) To be approved for the training of elevated blood lead (EBL) inspector/risk assessors prior to March 1, 1999, a course must be at least 32 training hours with a minimum of 8 hours devoted to hands-on training activities. Beginning March 1, 1999, a course must be at least 48 training hours with a minimum of 12 hours devoted to hands-on training activities. Elevated blood lead (EBL) inspector/risk assessor training courses shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of an elevated blood lead (EBL) inspector/risk assessor.

b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.

c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.

d. Lead-based paint inspection methods, including selection of rooms and components for sampling or testing to determine if a property is free of lead-based paint as specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development), and methods to determine if lead-based paint hazards are present in a property.*

e. Paint, dust, and soil sampling methodologies.*

f. Clearance standards and testing, including random sampling.*

g. Collection of background information to perform a risk assessment.

h. Sources of environmental lead contamination such as paint, surface dust and soil, and water.

i. Visual inspection to identify lead-based paint hazards.*

j. Lead hazard screen protocol.

k. Visual risk assessment protocol.

l. Sampling for other sources of lead exposure.*

m. Interpretation of lead-based paint and other lead sampling results, including all applicable federal, state, and local guidance or regulations pertaining to lead-based paint hazards.*

n. Development of hazard control options, the role of interim controls, and operations and maintenance activities to reduce lead-based paint hazards.*

o. Approved methods for conducting lead-based paint abatement and interim controls.

p. Prohibited methods for conducting lead-based paint abatement and interim controls.

q. Interior dust abatement and cleanup.

r. Soil and exterior dust abatement and cleanup.

s. Preparation of the final inspection report.

t. Record keeping.

u. Environmental and medical case management of elevated blood lead (EBL) children.

v. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(6) To be approved for the training of elevated blood lead (EBL) inspector/risk assessors who have already completed an approved lead inspector/risk assessor course, a course must be at least 8 training hours and shall cover at least the following subjects:

a. Role and responsibilities of an elevated blood lead (EBL) inspector/risk assessor.

b. Environmental and medical case management of elevated blood lead (EBL) children.

c. The course shall conclude with a course test. The student must achieve a score of at least 80 percent on the examination to successfully complete the course.

70.4(7) To be approved for the training of elevated blood lead (EBL) inspector/risk assessors who have already completed an approved visual risk assessor course, a course must be at least 28 training hours with a minimum of 8 hours devoted to hands-on training activities. The training course shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of an elevated blood lead (EBL) inspector/risk assessor.

b. Lead-based paint inspection methods, including selection of rooms and components for sampling or testing to determine if a property is free of lead-based paint as specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development), and methods to determine if lead-based paint hazards are present in a property.*

c. Collection of background information to perform a risk assessment.

d. Lead hazard screen protocol.

e. Visual risk assessment protocol.

f. Sampling for other sources of lead exposure.*

g. Interpretation of lead-based paint and other lead sampling results, including all applicable federal, state, and local guidance or regulations pertaining to lead-based paint hazards.*

h. Development of hazard control options, the role of interim controls, and operations and maintenance activities to reduce lead-based paint hazards.*

i. Preparation of the final inspection report.

j. Record keeping.

k. Environmental and medical case management of elevated blood lead (EBL) children.

l. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(8) To be approved for the training of lead abatement contractors, a course must be at least 40 training hours with a minimum of 12 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of a lead abatement contractor.

b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.

c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.

d. Liability and insurance issues relating to lead-based paint abatement.

e. Identification of lead-based paint and lead-based paint hazards.*

f. Interpretation of lead inspection reports.*

g. Development and implementation of an occupant protection plan and abatement report.

h. Respiratory protection and protective clothing.*

i. Employee information and training.

j. Approved methods for conducting lead-based paint abatement and interim controls.*

k. Prohibited methods for conducting lead-based paint abatement and interim controls.

l. Interior dust abatement and cleanup.*

m. Soil and exterior dust abatement and cleanup.*

n. Clearance standards and testing, including random sampling.

o. Cleanup and waste disposal.

p. Record keeping.

q. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(9) To be approved for the training of lead abatement contractors who have already completed an approved lead abatement worker course, a course must be at least 16 training hours with a minimum of 4 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of a lead abatement contractor.

b. Liability and insurance issues relating to lead-based paint abatement.

c. Interpretation of lead inspection reports.*

d. Development and implementation of an occupant protection plan and abatement report.

e. Employee information and training.

f. Clearance standards and testing, including random sampling.

g. Record keeping.

h. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(10) To be approved for the training of lead abatement workers, a course must be at least 24 training hours with a minimum of 8 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of a lead abatement worker.

b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.

c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.

d. Identification of lead-based paint and lead-based paint hazards.*

e. Approved methods for conducting lead-based paint abatement and interim controls.*

f. Prohibited methods for conducting lead-based paint abatement and interim controls.

g. Interior dust abatement and cleanup.*

h. Soil and exterior dust abatement and cleanup.*

i. Cleanup and waste disposal.

j. Respiratory protection and protective clothing.*

k. Personal hygiene.

l. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(11) To be approved for the training of visual risk assessors prior to September 15, 2000, a course must be at least 16 training hours with a minimum of 4 hours devoted to hands-on activities. Beginning September 15, 2000, a course must be at least 20 training hours with a minimum of 4 hours devoted to hands-on training activities. The training course shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of a visual risk assessor.

b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.

c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.

d. Methods of conducting visual risk assessments.*

e. Paint, dust, and soil sampling methodologies.*

f. Clearance standards and testing, including random sampling.*

g. Identification of lead-based paint hazards.*

h. Sources of environmental lead contamination such as paint, surface dust and soil, and water.

i. Visual inspection to identify lead-based paint hazards.*

j. Approved methods for conducting lead-based paint abatement and interim controls.

k. Prohibited methods for conducting lead-based paint abatement and interim controls.

l. Methods of interim controls and abatement for interior dust and cleanup.

m. Methods of interim controls and abatement for exterior dust and soil and cleanup.

n. Preparation of the final assessment report.

o. Preparation of clearance testing reports for interim controls.

p. Record keeping.

q. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(12) To be approved for the training of project designers, a course must be at least 48 instructional training hours with a minimum of 12 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of a lead abatement contractor.

b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.

c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.

d. Liability and insurance issues relating to lead-based paint abatement.

e. Identification of lead-based paint and lead-based paint hazards.*

f. Interpretation of lead inspection reports.*

g. Development and implementation of an occupant protection plan and abatement report.

h. Respiratory protection and protective clothing.*

i. Employee information and training.

j. Approved methods for conducting lead-based paint abatement and interim controls.*

k. Prohibited methods for conducting lead-based paint abatement and interim controls.

l. Interior dust abatement and cleanup.*

m. Soil and exterior dust abatement and cleanup.*

n. Clearance standards and testing, including random sampling.

o. Cleanup and waste disposal.

p. Record keeping.

q. Role and responsibilities of a project designer.

r. Development and implementation of an occupant protection plan for large-scale abatement projects.

s. Lead-based paint abatement and lead-based paint hazard reduction methods, including restricted practices for large-scale abatement projects.

t. Interior dust abatement/cleanup or lead hazard control and reduction methods for large-scale abatement projects.

u. Clearance standards and testing for large-scale abatement projects.

v. Integration of lead-based paint abatement methods with modernization and rehabilitation projects for large-scale abatement projects.

w. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(13) To be approved for the training of project designers who have already completed an approved lead abatement contractor course, a course must be at least 8 instructional training hours and shall cover at least the following subjects:

a. Role and responsibilities of a project designer.

b. Development and implementation of an occupant protection plan for large-scale abatement projects.

c. Lead-based paint abatement and lead-based paint hazard reduction methods, including restricted practices for large-scale abatement projects.

d. Interior dust abatement/cleanup or lead hazard control and reduction methods for large-scale abatement projects.

e. Clearance standards and testing for large-scale abatement projects.

f. Integration of lead-based paint abatement methods with modernization and rehabilitation projects for large-scale abatement projects.

g. The course shall conclude with a course test. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(14) To be approved for the training of project designers who have already completed an approved lead abatement worker course, a course must be at least 24 instructional training hours with a minimum of 4 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (*) indicate areas that require hands-on activities as an integral component of the course):

a. Role and responsibilities of a lead abatement contractor.

b. Liability and insurance issues relating to lead-based paint abatement.

c. Interpretation of lead inspection reports.*

d. Development and implementation of an occupant protection plan and abatement report.

e. Employee information and training.

f. Clearance standards and testing, including random sampling.

g. Record keeping.

h. Role and responsibilities of a project designer.

i. Development and implementation of an occupant protection plan for large-scale abatement projects.

j. Lead-based paint abatement and lead-based paint hazard reduction methods, including restricted practices for large-scale abatement projects.

k. Interior dust abatement/cleanup or lead hazard control and reduction methods for large-scale abatement projects.

l. Clearance standards and testing for large-scale abatement projects.

m. Integration of lead-based paint abatement methods with modernization and rehabilitation projects for large-scale abatement projects.

n. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(15) To be approved for refresher training of visual risk assessors, lead abatement contractors, lead abatement workers, and project designers, a course must be at least 8 training hours. To be approved for refresher training of lead inspector/risk assessors who completed an approved 24-hour training course or elevated blood lead (EBL) inspector/risk assessors who completed an approved 32-hour training course, a course must be at least 8 training hours to meet the recertification requirements of subrule 70.5(3). To be approved for refresher training of lead inspector/risk assessors and elevated blood lead (EBL) inspector/risk assessors to meet the recertification requirements of subrule 70.5(6), a course must be at least 16 training hours. All refresher courses shall cover at least the following topics:

a. A review of the curriculum topics of the initial certification course for the appropriate discipline as listed in subrules 70.4(3) to 70.4(14).

b. An overview of current safety practices relating to lead-based paint activities in general, as well as specific information pertaining to the appropriate discipline.

c. Current laws and regulations relating to lead-based paint activities in general, as well as specific information pertaining to the appropriate discipline.

d. Current technologies relating to lead-based paint activities in general, as well as specific information pertaining to the appropriate discipline.

e. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course.

70.4(16) Approvals of training courses shall expire three years after the date of issuance. The training manager shall submit the following at least 90 days prior to the expiration date for a course to be reapproved:

a. Sponsoring organization name, contact person, address, and telephone number.

b. A list of the courses for which reapproval is sought.

c. A description of any changes to the training staff, facility, equipment, or course materials since the approval of the training program.

d. A statement signed by the training manager stating that the training program complies at all times with rule 70.4(135).

e. A nonrefundable fee of $200.

70.4(17) The department shall consider a request for approval of a training course that has been approved by a state or tribe authorized by the U.S. Environmental Protection Agency.

a. The course shall be approved if it meets the requirements of rule 70.4(135).

b. If the course does not meet all of the requirements of rule 70.4(135), the department shall inform the training provider of additional topics and training hours that are needed to meet the requirements of rule 70.4(135).

641—70.5(135) Certification, interim certification, and recertification.

70.5(1) A person wishing to become a certified lead professional shall apply on forms supplied by the department. The applicant must submit:

a. A completed application form.

b. A certificate of completion of an approved course for the discipline in which the applicant wishes to become certified.

c. A person wishing to become a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall provide documentation of successful completion of the manufacturer's training course or equivalent for the X-ray fluorescence (XRF) analyzer that the inspector/risk assessor will use to conduct lead inspections.

d. Documentation that the applicant meets the additional experience and education requirements in subrule 70.5(2) for the discipline in which the applicant wishes to become certified. The following documents shall be submitted as evidence that the applicant has the education and work experience required by subrule 70.5(2):

(1) Official transcripts or diplomas as evidence of meeting the education requirements.

(2) Résumés, letters of reference, or documentation of work experience, as evidence of meeting the work experience requirements.

e. Beginning March 1, 2000, to become certified as a lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, lead abatement contractor, or project designer, a certificate showing that the applicant has passed the state certification examination in the discipline in which the applicant wishes to become certified.

f. A $50 nonrefundable fee.

g. A person may receive interim certification from the department as a lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, lead abatement contractor, or project designer by submitting the items required by paragraphs 70.5(1)*"a"* to *"d"* and *"f"* to the department. If the applicant completed an approved course prior to September 1, 1999, the interim certification shall expire on March 1, 2000. If the applicant completed an approved course on or after September 1, 1999, the interim certification shall expire six months from the date of completion of an approved course. An interim certification must be upgraded to a certification by submitting a certificate to the department showing that the applicant has passed the state certification examination as required by paragraph 70.5(1)*"e."* Interim certification is equivalent to certification.

70.5(2) Beginning September 1, 1999, to become certified by the department as a lead professional, an applicant must meet the education and experience requirements for the appropriate discipline:

a. Lead inspector/risk assessors and elevated blood lead (EBL) inspector/risk assessors must meet one of the following requirements:

(1) Bachelor's degree and one year of related experience (e.g., lead, environmental health, public health, housing inspection, building trades).

(2) Associate's degree and two years of related experience (e.g., lead, environmental health, public health, housing inspection, building trades).

(3) High school diploma and three years of related experience (e.g., lead, environmental health, public health, housing inspection, building trades).

(4) Certification as an industrial hygienist, professional engineer, registered architect, registered sanitarian, registered environmental health specialist, or registered nurse.

b. Lead abatement contractors must meet one of the following requirements:

(1) One year of experience as a certified lead abatement worker.

(2) Two years of related experience or education (e.g., lead, housing inspection, building trades, property management and maintenance).

c. No additional education or experience is required for lead abatement workers.

d. Visual risk assessors must meet one of the following requirements:

(1) Associate's degree.

(2) High school diploma and one year of related experience (e.g., lead, environmental health, public health, housing inspection, building trades).

(3) Certification as an industrial hygienist, professional engineer, registered architect, registered sanitarian, registered environmental health specialist, or registered nurse.

e. Project designers must meet one of the following requirements:

(1) Bachelor's degree in engineering, architecture, or a related profession, and one year of experience in building construction and design or a related field.

(2) Four years of experience in building construction and design or a related field.

70.5(3) Certifications issued prior to September 1, 1999, shall expire on February 29, 2000. By March 1, 2000, lead professionals certified prior to September 1, 1999, must be recertified by submitting the following:

a. A completed application form.

b. For lead inspector/risk assessors, a certificate showing the completion of additional training hours in an approved course to meet the total training hours required by subrule 70.4(3) and the completion of an 8-hour refresher course.

c. For elevated blood lead (EBL) inspector/risk assessors, a certificate showing the completion of additional training hours in an approved course to meet the total training hours required by subrule 70.4(4) and the completion of an 8-hour refresher course.

d. Documentation that the applicant meets the experience and education requirements in subrule 70.5(2) for the discipline in which the applicant wishes to become certified. The following documents shall be submitted as evidence that the applicant has the education and work experience required by subrule 70.5(2):

(1) Official transcripts or diplomas as evidence of meeting the education requirements.

(2) Résumés, letters of reference, or documentation of work experience, as evidence of meeting the work experience requirements.

e. For lead abatement contractors, lead abatement workers, project designers, and visual risk assessors, if the date on which the applicant completed an approved training course is three years or more before the date of recertification, a certificate showing that the applicant has successfully completed an approved refresher training course for the appropriate discipline.

f. A certificate showing that the applicant has passed the state certification examination in the discipline in which the applicant wishes to become certified.

g. A $50 nonrefundable fee.

70.5(4) By September 15, 2000, visual risk assessors certified prior to July 1, 2000, must be recertified by submitting a certificate showing the completing of additional training hours in an approved course to meet the total training hours required by subrule 70.4(11) and the completion of an 8-hour refresher course.

70.5(5) All agencies that perform or offer to perform elevated blood lead (EBL) inspections after September 15, 2000, must be certified by the department. An agency wishing to become a certified elevated blood lead (EBL) inspection agency shall apply on forms supplied by the department. The agency must submit:

a. A completed application form.

b. Documentation that the agency has the authority to require the repair of lead hazards identified through an elevated blood lead (EBL) inspection.

c. Documentation that the agency employs or has contracted with a certified elevated blood lead (EBL) inspector/risk assessor to provide environmental case management of all elevated blood lead (EBL) children in the agency's service area, including follow-up to ensure that lead-based paint hazards identified as a result of elevated blood lead (EBL) inspections are corrected, and that lead-based paint activities will be conducted only by appropriately certified lead professionals. In addition, the agency must document that the agency and its employees or contractors will follow the work practice standards in rule 70.6(135) for conducting lead-based paint activities.

d. The certified elevated blood lead (EBL) inspection agency must maintain all records required by rule 70.6(135).

70.5(6) Beginning March 1, 2000, individuals certified as lead professionals must be recertified each year. To be recertified, lead professionals must submit the following:

a. A completed application form.

b. A $50 nonrefundable fee.

c. Every three years, a certificate showing that the applicant has successfully completed an approved refresher training course for the appropriate discipline. If the applicant completed an approved training program prior to March 1, 2000, the initial refresher training course must be completed no more than three years after the date on which the applicant completed an approved training program.

70.5(7) The department shall approve the state certification examinations for the disciplines of lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, lead abatement contractor, and project designer. The state certification examination may not be administered by the provider of an approved course.

a. An individual may take the state certification examination no more than three times within six months of receiving a certificate of completion from an approved course.

b. If an individual does not pass the state certification examination within six months of receiving a certificate of completion from an approved course, the individual must retake the appropriate approved course before reapplying for certification.

70.5(8) Reciprocity. Each applicant for certification who is certified in any of the disciplines specified in this rule in another state may request reciprocal certification. The department shall evaluate the requirements for certification to determine that the requirements for certification in such other state are as protective of health and the environment as the requirements for certification in Iowa. If the department determines that the requirements for certification in such other state are as protective of health and the environment as the requirements for certification in Iowa, the applicant may be certified after passing a proctored test covering Iowa-specific lead information with a score of at least 80 percent. Each applicant for certification pursuant to this subrule shall submit the appropriate application accompanied by the fee for each discipline as specified in rule 70.5(135).

641—70.6(135) Work practice standards for conducting lead-based paint activities in target housing and child-occupied facilities.

70.6(1) Prior to March 1, 2000, when performing any lead-based paint activity described as an inspection, elevated blood lead (EBL) inspection, lead hazard screen, risk assessment, visual risk assessment, or lead abatement, a certified individual must perform that activity in compliance with the appropriate requirements below. Beginning March 1, 2000, all lead-based paint activities shall be performed according to the work practice standards in rule 70.6(135) and a certified individual must perform that activity in compliance with the appropriate requirements below.

70.6(2) A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor must conduct lead inspections according to the following standards. Beginning March 1, 2000, lead inspections shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

a. When conducting an inspection, the certified lead inspector/risk assessor shall use the documented methodologies, including selection of rooms and components for sampling or testing, specified in Chapter 7 of the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development).

b. Paint shall be sampled using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface.

c. If lead-based paint is identified through an inspection, the certified lead inspector/risk assessor must conduct a visual inspection to determine the presence of lead-based paint hazards and any other potential lead hazards.

d. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility inspected and shall provide a copy of this report to the person requesting the inspection. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of each written report for no fewer than three years. The inspection report shall include, at least:

(1) Date of each inspection;

(2) Address of building;

(3) Date of construction;

(4) Apartment numbers (if applicable);

(5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;

(6) Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the investigation;

(7) Name, address, and telephone number of each laboratory conducting an analysis of collected samples;

(8) Each testing method and device and sampling procedure employed for paint analysis, including quality control data and, if used, the serial number of any X-ray fluorescence (XRF) device;

(9) Specific locations of each painted component tested for the presence of lead-based paint;

(10) The results of the inspection expressed in terms appropriate to the sampling method used;

(11) A description of the location, type, and severity of identified lead-based paint hazards, and any other potential lead hazards; and

(12) A description of interim controls and abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure.

70.6(3) A certified elevated blood lead (EBL) inspector/risk assessor must conduct elevated blood lead (EBL) inspections according to the following standards. Beginning March 1, 2000, elevated blood lead (EBL) inspections shall be conducted only by a certified elevated blood lead (EBL) inspector/risk assessor.

a. When conducting an elevated blood lead (EBL) inspection, the certified elevated blood lead (EBL) inspector/risk assessor shall use the documented methodologies, including selection of rooms and components for sampling or testing, specified in Chapter 7 of the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development).

b. Paint shall be sampled using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface.

c. If lead-based paint is identified through an inspection, the certified elevated blood level (EBL) inspector/risk assessor must conduct a visual inspection to determine the presence of lead-based paint hazards and any other potential lead hazards.

d. A certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where an elevated blood lead (EBL) inspection has been conducted and shall provide a copy of this report to the owner and the occupant of the dwelling. The report shall include, at least:

(1) Date of each elevated blood lead (EBL) inspection;

(2) Address of building;

(3) Date of construction;

(4) Apartment numbers (if applicable);

(5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;

(6) Name, signature, and certification number of each certified elevated blood lead (EBL) inspector/risk assessor conducting the investigation;

(7) Name, address, and telephone number of each laboratory conducting an analysis of collected samples;

(8) Each testing method and device and sampling procedure employed for paint analysis, including quality control data and, if used, the serial number of any X-ray fluorescence (XRF) device;

(9) Specific locations of each painted component tested for the presence of lead-based paint;

(10) The results of the inspection expressed in terms appropriate to the sampling method used;

(11) A description of the location, type, and severity of identified lead-based paint hazards, and any other potential lead hazards; and

(12) A description of interim controls and abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure.

e. A certified elevated blood lead (EBL) inspector/risk assessor shall maintain a written record for each residential dwelling or child-occupied facility where an elevated blood lead (EBL) inspection has been conducted for no fewer than ten years. The record shall include, at least:

(1) A copy of the written report required by paragraph 70.6(3)*"d."*

(2) Blood lead test results for the elevated blood lead (EBL) child.

(3) A record of conversations held with the owners and occupants of each residential dwelling or child-occupied facility prior to, during, and after the EBL inspection.

(4) Records of follow-up visits made to each residential dwelling or child-occupied facility where lead-based paint hazards are identified to ensure that lead-based paint hazards are safely repaired.

70.6(4) A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor must conduct lead hazard screens according to the following standards. Beginning March 1, 2000, lead hazard screens shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

a. Background information regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years shall be collected.

b. A visual inspection of the residential dwelling or child-occupied facility shall be conducted to determine if any deteriorated paint is present and to locate at least two dust sampling locations.

c. If deteriorated paint is present, each surface with deteriorated paint which is determined to have a distinct painting history must be tested for the presence of lead.

d. In residential dwellings, two composite dust samples shall be collected. One sample shall be collected from the floors and the other from the window well and window trough in rooms, hallways, or stairwells where at least one child under the age of six years is most likely to come in contact with dust.

e. In multifamily dwellings and child-occupied facilities, a composite dust sample shall also be collected from common areas where at least one child under the age of six years is likely to come in contact with dust.

f. Dust samples shall be collected using the documented methodologies specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development). Dust samples shall be analyzed by a recognized laboratory to determine the level of lead.

g. Paint shall be sampled using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface.

h. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where a lead hazard screen is conducted and shall provide a copy of this report to the person requesting the lead hazard screen. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of each written report for no fewer than three years. The report shall include, at least:

(1) Date of each lead hazard screen;

(2) Address of building;

(3) Date of construction;

(4) Apartment numbers (if applicable);

(5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;

(6) Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the investigation;

(7) Name, address, and telephone number of each recognized laboratory conducting an analysis of collected samples;

(8) Results of the visual inspection;

(9) Each testing method and device and sampling procedure employed for paint analysis, including quality control data and, if used, the serial number of any X-ray fluorescence (XRF) device;

(10) Specific locations of each painted component tested for the presence of lead-based paint;

(11) All results of laboratory analysis of collected paint, dust, and soil samples;

(12) Any other sampling results;

(13) Background information collected regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years; and

(14) Recommendations, if warranted, for a follow-up lead inspection or risk assessment, and, as appropriate, any further actions.

70.6(5) A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor must conduct risk assessments according to the following standards. Beginning March 1, 2000, risk assessments shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

a. Background information regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years shall be collected.

b. A visual inspection for risk assessment shall be undertaken to locate the existence of deteriorated paint and other potential lead hazards and to assess the extent and causes of the paint deterioration.

c. If deteriorated paint is present, each surface with deteriorated paint which is determined to have a distinct painting history must be tested for the presence of lead.

d. Accessible, friction, and impact surfaces having a distinct painting history shall be tested for the presence of lead.

e. In residential dwellings, dust samples shall be collected from the windowsill, window trough, and floor in all living areas where at least one child is most likely to come in contact with dust. Dust samples may be either composite or single-surface samples.

f. In multifamily dwellings and child-occupied facilities, dust samples shall also be collected from common areas adjacent to the sampled residential dwellings or child-occupied facility and in other common areas where the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor determines that at least one child under the age of six years is likely to come in contact with dust. Dust samples may be either composite or single-surface samples.

g. In child-occupied facilities, dust samples shall be collected from the window well, window trough, and floor in each room, hallway, or stairwell utilized by one or more children, under the age of six years, and in other common areas where the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor determines that at least one child under the age of six years is likely to come in contact with dust. Dust samples may be either composite or single-surface samples.

h. Soil samples shall be collected in exterior play areas and drip line/foundation areas where bare soil is present.

i. Dust samples, soil, and paint samples shall be collected using the documented methodologies specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development). Dust and soil samples shall be analyzed by a recognized laboratory to determine the level of lead.

j. Paint shall be sampled using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface.

k. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where a risk assessment is conducted and shall provide a copy of the report to the person requesting the risk assessment. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of the report for no fewer than three years. The report shall include, at least:

(1) Date of each risk assessment;

(2) Address of building;

(3) Date of construction;

(4) Apartment numbers (if applicable);

(5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;

(6) Name, signature, and certification number of each certified lead inspector/risk assessor conducting the investigation;

(7) Name, address, and telephone number of each recognized laboratory conducting an analysis of collected samples;

(8) Results of the visual inspection;

(9) Each testing method and device and sampling procedure employed for paint analysis, including quality control data and, if used, the serial number of any X-ray fluorescence (XRF) device;

(10) Specific locations of each painted component tested for the presence of lead-based paint;

(11) All results of laboratory analysis of collected paint, dust, and soil samples;

(12) Any other sampling results;

(13) Background information collected regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years;

(14) To the extent that they are used as part of the lead-based paint hazard determination, the results of any previous inspections or analyses for the presence of lead-based paint, or other assessments of lead-based paint hazards;

(15) A description of the location, type, and severity of identified lead-based paint hazards, and any other potential lead hazards; and

(16) A description of interim controls and abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure.

70.6(6) A certified lead abatement contractor or certified lead abatement worker must conduct lead abatement according to the following standards. Beginning March 1, 2000, lead abatement shall be conducted only by a certified lead abatement contractor or a certified lead abatement worker.

a. A certified lead abatement contractor must be on site during all work site preparation and during the postabatement cleanup of work areas. At all other times when lead abatement is being conducted, the certified lead abatement contractor shall be on site or available by telephone, pager, or answering service, and be able to be present at the work site in no more than two hours.

b. A certified lead abatement contractor shall ensure that lead abatement is conducted according to all federal, state, and local requirements.

c. A certified lead abatement contractor shall notify the department in writing at least seven days prior to the commencement of lead abatement in a residential dwelling or child-occupied facility. The notification shall include the following information:

(1) The address, including apartment numbers, where abatement will be conducted.

(2) The dates when abatement will be conducted.

(3) The name, address, telephone number, and Iowa certification number of the certified firm that will conduct the work.

(4) The name, address, telephone number, and Iowa certification number for the certified abatement contractor who will serve as the contact person for the project.

(5) The name, address, and telephone number of the property owner.

(6) Whether the dwelling is owner-occupied or a rental dwelling.

(7) If the dwelling is an occupied rental, the names of the occupants.

(8) The approximate year that the dwelling was built.

(9) A brief description of the abatement work to be done.

d. A certified lead abatement contractor or a certified project designer shall develop an occupant protection plan for all lead abatement projects prior to starting lead abatement and shall implement the occupant protection plan during the lead abatement project. The occupant protection plan shall be unique to each residential dwelling or child-occupied facility. The occupant protection plan shall describe the measures and management procedures that will be taken during the abatement to protect the building occupants from exposure to any lead-based paint hazards.

e. Approved methods must be used to conduct lead abatement and prohibited work practices must not be used to conduct lead abatement. The following are prohibited work practices:

(1) Open-flame burning or torching of lead-based paint.

(2) Machine sanding or grinding or abrasive blasting or sandblasting of lead-based paint unless used with High Efficiency Particulate Air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at 99.97 percent or greater efficiency.

(3) Uncontained water blasting of lead-based paint.

(4) Dry scraping or dry sanding of lead-based paint except in conjunction with the use of a heat gun or around electrical outlets.

(5) Operating a heat gun at a temperature at or above 1100 degrees Fahrenheit.

f. Soil abatement shall be conducted using one of the following methods:

(1) If soil is removed, the lead-contaminated soil shall be replaced with soil that is not lead-contaminated.

(2) If soil is not removed, the lead-contaminated soil shall be permanently covered.

g. Postabatement clearance procedures shall be conducted by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor using the following procedures:

(1) Following an abatement, a visual inspection shall be performed to determine if deteriorated paint surfaces or visible amounts of dust, debris, or residue are still present. If deteriorated paint surfaces or visible amounts of dust, debris, or residue are present, these conditions must be eliminated prior to the continuation of the clearance procedures.

(2) Following the visual inspection and any required postabatement cleanup, clearance sampling for lead-contaminated dust shall be conducted. Clearance sampling may be conducted by employing single-surface sampling or composite dust sampling.

(3) Dust samples shall be collected a minimum of one hour after the completion of final postabatement cleanup activities.

(4) Dust samples shall be collected using the documented methodologies specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development). Dust samples shall be analyzed by a recognized laboratory to determine the level of lead.

(5) The following postabatement clearance activities shall be conducted as appropriate based upon the extent or manner of abatement activities conducted in the residential dwelling or child-occupied facility:

1. After conducting an abatement with containment between abated and unabated areas, one dust sample shall be taken from one windowsill and window trough (if available) and one dust sample shall be taken from the floor of no fewer than four rooms, hallways, or stairwells within the containment area. In addition, one dust sample shall be taken from the floor outside the containment area. If there are fewer than four rooms, hallways, or stairwells within the containment area, then all rooms, hallways, and stairwells shall be sampled.

2. After conducting an abatement with no containment, two dust samples shall be taken from no fewer than four rooms, hallways, or stairwells in the residential dwelling or child-occupied facility. One dust sample shall be taken from one windowsill and window trough (if available) and one dust sample shall be taken from the floor of each room, hallway, or stairwell selected. If there are fewer than four rooms, hallways, or stairwells within the containment area, then all rooms, hallways, and stairwells shall be sampled.

3. Following an exterior abatement, a visual inspection shall be conducted. All horizontal surfaces in the outdoor living area closest to the abated surface shall be found to be cleaned of visible dust and debris. In addition, a visual inspection shall be conducted to determine the presence of paint chips on the drip line or next to the foundation below any exterior surface abated. If visible dust, debris, or paint chips are present, they must be removed from the site and properly disposed of according to all applicable federal, state, and local standards.

(6) The rooms, hallways, and stairwells selected for sampling shall be selected using the documented methodologies specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development).

(7) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall compare the residual lead level as determined by the laboratory analysis from each dust sample with applicable clearance levels for lead in dust on floors and window troughs. If the residual lead levels in a dust sample exceed the clearance levels, then all the components represented by the failed dust sample shall be recleaned and retested until clearance levels are met.

h. In a multifamily dwelling with similarly constructed and maintained residential dwellings, random sampling for the purpose of clearance may be conducted if the following conditions are met:

(1) The certified lead abatement contractors and certified lead abatement workers who abate or clean the dwellings do not know which residential dwellings will be selected for the random sampling.

(2) A sufficient number of residential dwellings are selected for dust sampling to provide a 95 percent level of confidence that no more than 5 percent or 50 of the residential dwellings (whichever is smaller) in the randomly sampled population exceed the appropriate clearance levels.

(3) The randomly selected residential dwellings shall be sampled and evaluated for clearance according to the procedures found in paragraph 70.6(6)*"g."*

i. The certified lead abatement contractor or a certified project designer shall prepare an abatement report containing the following information:

(1) Starting and completion dates of the lead abatement project.

(2) The name and address of each certified lead abatement contractor and certified lead abatement worker conducting the abatement.

(3) The occupant protection plan required by paragraph 70.6(6)*"d."*

(4) The name, address, and signature of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting clearance sampling, the date on which the clearance testing was conducted, and the results of all postabatement clearance testing and all soil analyses, if applicable.

(5) The name and address of each laboratory that conducted the analysis of clearance samples and soil samples.

(6) A detailed written description of the lead abatement project, including lead abatement methods used, locations of rooms and components where lead abatement occurred, reasons for selecting particular lead abatement methods, and any suggested monitoring of encapsulants or enclosures.

(7) Maintain all reports and plans required in this subrule for a minimum of three years.

(8) Provide a copy of all reports required by this subrule to the building owner who contracted for the lead abatement.

70.6(7) A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified visual risk assessor must conduct visual risk assessments according to the following standards. Beginning March 1, 2000, visual risk assessments shall be conducted only by a certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified visual risk assessor.

a. Background information regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years shall be collected.

b. A visual inspection for risk assessment shall be undertaken to locate the existence of deteriorated paint and other potential lead hazards and to assess the extent and causes of the paint deterioration.

c. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified visual risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where a visual risk assessment is conducted and shall provide a copy of the report to the person requesting the visual risk assessment. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified visual risk assessor shall maintain a copy of the report for no fewer than three years. The report shall include, at least:

(1) Date of each visual risk assessment;

(2) Address of building;

(3) Date of construction;

(4) Apartment numbers (if applicable);

(5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;

(6) Name, signature, and certification number of each certified visual risk assessor, certified lead inspector/risk assessor, or certified elevated blood lead (EBL) inspector/risk assessor conducting the visual risk assessment;

(7) Specific locations of painted components identified as likely to contain lead-based paint and likely to be lead-based paint hazards; and

(8) Information for the owner and occupants on how to reduce lead hazards in the residential dwelling or child-occupied facility.

70.6(8) A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified visual risk assessor must conduct clearance testing according to the following standards. Beginning March 1, 2000, clearance testing following lead abatement shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor. Beginning September 15, 2000, clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, and rehabilitation pursuant to 24 CFR 35.1340 shall be conducted only by certified visual risk assessors, certified lead inspector/risk assessors, or certified elevated blood lead (EBL) inspectors.

a. Clearance testing following abatement shall be conducted according to paragraph 70.6(6)*"g."*

b. Clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, and rehabilitation pursuant to 24 CFR 35.1340 shall be conducted according to the following standards:

(1) A certified visual risk assessor shall perform clearance testing only for a single-family property or for individual dwelling units and associated common areas in a multiunit property. A certified visual risk assessor shall not perform clearance testing using random sampling of dwelling units or common areas in multifamily properties unless the clearance testing is approved by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor and the report is signed by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

(2) A visual inspection shall be performed to determine if deteriorated paint surfaces or visible amounts of dust, debris, or residue are still present. Both exterior and interior painted surfaces shall be examined for the presence of deteriorated paint. If deteriorated paint surfaces or visible amounts of dust, debris, or residue are present, these conditions must be eliminated prior to the continuation of the clearance testing. However, elimination of deteriorated paint is not required if it has been determined through a lead-based paint inspection that the deteriorated paint is not lead-based paint. If exterior painted surfaces have been disturbed by the interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation, the visual inspection shall include an assessment of the ground and any outdoor living areas close to the affected exterior painted surfaces. Visual dust or debris in living areas shall be cleaned up and visible paint chips on the ground shall be removed and properly disposed of according to all applicable federal, state, and local standards.

(3) Following the visual inspection and any required cleanup, clearance sampling for lead-contaminated dust shall be conducted. Clearance sampling may be conducted by employing single-surface sampling or composite dust sampling.

(4) Dust samples shall be collected a minimum of one hour after the completion of final cleanup activities.

(5) Dust samples shall be collected using the documented methodologies specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development). Dust samples shall be analyzed by a recognized laboratory to determine the level of lead.

(6) The following clearance activities shall be conducted as appropriate based upon the extent or manner of interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation conducted in the residential dwelling or child-occupied facility:

1. After conducting interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation, with containment between treated and untreated areas, one dust sample shall be taken from one windowsill and window trough (if available) and one dust sample shall be taken from the floor of no fewer than four rooms, hallways, or stairwells within the containment area. In addition, one dust sample shall be taken from the floor outside the containment area. If there are fewer than four rooms, hallways, or stairwells within the containment area, then all rooms, hallways, and stairwells shall be sampled.

2. After conducting interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation, with no containment, two dust samples shall be taken from no fewer than four rooms, hallways, or stairwells in the residential dwelling or child-occupied facility. One dust sample shall be taken from one windowsill and window trough (if available) and one dust sample shall be taken from the floor of each room, hallway, or stairwell selected. If there are fewer than four rooms, hallways, or stairwells within the containment area, then all rooms, hallways, and stairwells shall be sampled.

(7) The rooms, hallways, and stairwells selected for sampling shall be selected using the documented methodologies specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (1995, U.S. Department of Housing and Urban Development).

(8) The certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified visual risk assessor shall compare the residual lead level as determined by the laboratory analysis from each dust sample with applicable clearance levels for lead in dust on floors and window troughs. If the residual lead levels in a dust sample exceed the clearance levels, then all the components represented by the failed dust sample shall be recleaned and retested until clearance levels are met.

c. In a multifamily dwelling with similarly constructed and maintained residential dwellings, random sampling for the purpose of clearance may be conducted if the following conditions are met:

(1) The contractors and the workers who conducted the interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation do not know which residential dwellings will be selected for the random sampling.

(2) A sufficient number of residential dwellings are selected for dust sampling to provide a 95 percent level of confidence that no more than 5 percent or 50 of the residential dwellings (whichever is smaller) in the randomly sampled population exceed the appropriate clearance levels.

(3) The randomly selected residential dwellings shall be sampled and evaluated for clearance according to the procedures found in paragraph 70.6(6)*"g."*

d. A clearance report must be prepared that provides documentation of the lead abatement, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation as well as the clearance testing. When lead abatement is performed, the report shall be an abatement report in accordance with paragraph 70.6(6)*"h."* When interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation are performed, the clearance report shall include the following information:

(1) The address of the residential property and, if only part of a multifamily property is affected, the specific dwelling units and common areas affected.

(2) The following information regarding the clearance testing:

1. The date(s) of the clearance testing.

2. The name, address, and signature of each certified lead professional performing the clearance examination, including the certification number.

3. The results of the visual inspection for the presence of deteriorated paint and visible dust, debris, residue, or paint chips.

4. The results of the analysis of dust samples, in micrograms per square foot, by location of sample.

5. The name and address of each recognized laboratory that conducted the analysis of the dust samples, including the identification number for each such laboratory recognized by EPA under Section 405(b) of the Toxic Substances Control Act (15 U.S.C. 2685(b)).

(3) The following information on the interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation for which clearance testing was performed:

1. The start and completion dates of the interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation.

2. The name and address of each firm or organization conducting the interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation and the name of each supervisor assigned.

3. A detailed written description of the interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation, including the methods used, locations of exterior surfaces, interior rooms, common areas, and components where the hazard reduction activity occurred, and any suggested monitoring or encapsulants or enclosures.

4. If interim control of soil hazards was conducted, a detailed description of the location(s) of the interim controls and the method(s) used.

e. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of the clearance testing information included in the abatement report specified in paragraph 70.6(6)*"h"* for no fewer than three years. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of the clearance testing report specified in paragraph 70.6(8)*"d"* for no fewer than three years.

f. The clearance standards in 24 CFR 35.1320(b)(2) shall apply. If the results of clearance testing equal or exceed the standards, the dwelling unit, work site, or common area represented by the sample fails the clearance testing.

g. All surfaces represented by a failed clearance sample shall be recleaned or treated by interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation, and retested until the applicable clearance level in 24 CFR 35.1320(b)(2) is met.

h. Clearance testing shall be performed by persons or entities independent of those performing interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation, unless the designated party uses qualified in-house employees to conduct clearance testing. An in-house employee shall not conduct both interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation and the clearance examination for this work.

70.6(9) A certified elevated blood lead (EBL) inspection agency shall maintain the written records for all elevated blood lead (EBL) inspections conducted by persons that the agency employs or contracts with to provide elevated blood lead (EBL) inspections in the agency's service area.

70.6(10) A person may be certified as a lead inspector/risk assessor, visual risk assessor, or elevated blood lead (EBL) inspector/risk assessor and as a lead abatement contractor or lead abatement worker. Except as specified by paragraph 70.6(8)*"h,"* a person who is certified both as a lead inspector/risk assessor, visual risk assessor, or elevated blood lead (EBL) inspector/risk assessor and as a lead abatement contractor or lead abatement worker shall not provide both lead inspection or visual risk assessment and lead abatement services at the same site unless a written consent or waiver, following full disclosure by the person, is obtained from the owner or manager of the site.

70.6(11) Any paint chip, dust, or soil samples collected pursuant to the work practice standards contained in subrules 70.6(2) to 70.6(6) shall be collected by persons certified as a lead inspector/risk assessor or an elevated blood lead (EBL) inspector/risk assessor. Any paint chip, dust, or soil samples collected pursuant to the work practice standards contained in subrule 70.6(8) for clearance testing following lead abatement shall be collected by persons certified as a lead inspector/risk assessor or an elevated blood lead (EBL) inspector/risk assessor. Any paint chip, dust, or soil samples collected pursuant to the work practice standards contained in subrule 70.6(8) for clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, and rehabilitation pursuant to 24 CFR 35.1340 shall be conducted only by certified visual risk assessors, certified lead inspector/risk assessors, or certified elevated blood lead (EBL) inspectors. Any paint chip, dust, or soil samples collected pursuant to the work practice standards contained in rule 70.6(135) shall be analyzed by a recognized laboratory.

70.6(12) Composite dust sampling shall be conducted only in the situations specified in subrules 70.6(4) to 70.6(6) and 70.6(8). If composite sampling is conducted, it shall meet the following requirements:

a. Composite dust samples shall consist of at least two subsamples.

b. Every component that is being tested shall be included in the sampling.

c. Composite dust samples shall not consist of subsamples from more than one type of component.

641—70.7(135) Firms. All firms that perform or offer to perform lead-based paint activities other than elevated blood lead (EBL) inspections after September 15, 2000, must be certified by the department. Firms shall employ only appropriately certified employees to conduct lead-based paint activities, and the firm and its employees shall follow the work practice standards in 641—70.6(135) for conducting lead-based paint activities.

70.7(1) A firm wishing to be certified shall apply on forms supplied by the department. The firm must submit:

a. A completed application form.

b. Documentation that the firm will employ only appropriately certified lead professionals to perform lead-based paint activities. In addition, the firm must document that the agency and its employees or contractors will follow the work practice standards in rule 70.6(135) for conducting lead-based paint activities.

c. The certified firm must maintain all records required by rule 70.6(135).

70.7(2) Reserved.

641—70.8(135) Enforcement.

70.8(1) The department may enter premises or facilities where violations of the provisions regarding lead-based paint activities may occur for the purpose of conducting inspections.

70.8(2) The department may enter premises or facilities where training programs conduct business.

70.8(3) The department may take samples and review records as part of the lead-based paint activities inspection process.

70.8(4) The following are considered to be in violation of this chapter:

a. Failure or refusal to comply with any requirements of rules 70.3(135) to 70.6(135).

b. Failure or refusal to establish, maintain, provide, copy, or permit access to records or reports as required by rules 70.3(135) to 70.6(135).

c. Failure or refusal to permit entry or inspection as described in subrules 70.8(1) to 70.8(3).

d. Obtaining certification through fraudulent representation.

e. Failing to obtain certification from the department and performing work requiring certification at a job site.

f. Fraudulently obtaining certification and engaging in any lead-based paint activities requiring certification.

g. Violators are subject to civil penalties pursuant to Iowa Code section 135.105A.

641—70.9(135) Denial, suspension or revocation of certification and denial, suspension, revocation, or modification of course approval.

70.9(1) The department may deny an application for certification, or may suspend or revoke a certification, when it finds that the applicant, certified lead professional, certified elevated blood lead (EBL) inspection agency, or certified firm has committed any of the following acts:

a. Obtained documentation of training through fraudulent means.

b. Gained admission to and completed an accredited training program through misrepresentation of admission requirements.

c. Obtained certification through misrepresentation of certification requirements or related documents dealing with education, training, professional registration, or experience.

d. Performed work requiring certification at a job site without having proof of certification.

e. Permitted the duplication or use of the individual's own certificate by another.

f. Performed work for which certification is required, but for which appropriate certification has not been received.

g. Failed to follow the standards of conduct required by rule 70.6(135).

h. Failed to comply with federal, state, or local lead-based paint statutes and regulations.

i. For certified elevated blood lead (EBL) inspection agencies and certified firms, performed work for which certification is required with individuals who are not appropriately certified.

70.9(2) The department may deny, suspend, revoke, or modify the approval for a course when it finds that the training program, training manager, or other person with supervisory authority over the course has:

a. Misrepresented the contents of a training course to the department or to the student population.

b. Failed to submit required information or notifications in a timely manner.

c. Failed to maintain required records.

d. Falsified approval records, instructor qualifications, or other information or documentation related to course approval.

e. Failed to comply with the training standards and requirements in rule 70.4(135).

f. Made false or misleading statements to the department in its application for approval or reapproval which the department relied upon in approving the application.

70.9(3) Complaints. Complaints regarding a certified lead professional, a certified elevated blood lead (EBL) inspection agency, a certified firm, or an approved course shall be submitted in writing to the Iowa Department of Public Health, Lead Poisoning Prevention Program, 321 East 12th Street, Des Moines, Iowa 50319-0075. The complainant shall provide:

a. The name of the certified lead professional, certified elevated blood lead (EBL) inspection agency, or certified firm and the specific details of the action(s) by the certified lead professional, certified elevated blood lead (EBL) inspection agency, or certified firm that did not comply with the rules, or

b. The name of the sponsoring person or organization of an approved course and the specific way(s) that an approved course did not comply with the rules.

70.9(4) Appeals.

a. Notice of denial, suspension or revocation of certification, or denial, suspension, revocation, or modification of course approval shall be sent to the affected individual or organization by restricted certified mail, return receipt requested, or by personal service. The affected individual or organization shall have a right to appeal the denial, suspension or revocation.

b. An appeal of a denial, suspension or revocation shall be submitted by certified mail, return receipt requested, within 30 days of the receipt of the department's notice to the Iowa Department of Public Health, Lead Poisoning Prevention Program, 321 East 12th Street, Des Moines, Iowa 50319-0075. If such a request is made within the 30-day time period, the notice of denial, suspension or revocation shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, suspension or revocation has been or will be removed. After the hearing, or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the denial, suspension or revocation. If no appeal is submitted within 30 days, the denial, suspension or revocation shall become the department's final agency action.

c. Upon receipt of an appeal that meets contested case status, the appeal shall be transmitted to the department of inspections and appeals within five working days of receipt pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the denial, suspension or revocation is based shall be provided to the department of inspections and appeals.

d. The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

e. When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. The proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in paragraph 70.9(4)*"f."*

f. Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for appeal shall state the reason for appeal.

g. Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing or submission to the director. The record shall include the following:

(1) All pleadings, motions, and rulings.

(2) All evidence received or considered and all other submissions by recording or transcript.

(3) A statement of all matters officially noticed.

(4) All questions and offers of proof, objection, and rulings thereon.

(5) All proposed findings and exceptions.

(6) The proposed findings and order of the administrative law judge.

h. The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

i. It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

j. Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service to the Iowa Department of Public Health, Lead Poisoning Prevention Program, 321 East 12th Street, Des Moines, Iowa 50319-0075.

k. The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

70.9(5) Public notification.

a. The public shall be notified of the suspension, revocation, modification, or reinstatement of course approval through appropriate mechanisms.

b. The department shall maintain a list of courses for which the approval has been suspended, revoked, modified, or reinstated.

641—70.10(135) Waivers. Rules in this chapter are not subject to waiver or variance pursuant to 641—Chapter 178 or any other provision of law.

These rules are intended to implement Iowa Code section 135.105A.

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◊Two ARCs

CHAPTER 131
EMERGENCY MEDICAL SERVICES
PROVIDER EDUCATION/TRAINING/CERTIFICATION

641—131.1(147A) Definitions. For the purpose of these rules, the following definitions shall apply:

"ACLS" or *"advanced cardiac life support"* means training and successful course completion in advanced cardiac life support according to American Heart Association standards.

"AED" means automated external defibrillator.

"Automated defibrillator" means any external semiautomated device that determines whether defibrillation is required.

"Basic care" means treatment interventions, appropriate to certification level, that provide minimum care to the patient including, but not limited to, CPR, bandaging, splinting, oxygen administration, spinal immobilization, oral airway insertion and suctioning, antishock garment, vital sign assessment and administration of over-the-counter drugs.

"CEH" means "continuing education hour" which is based upon a minimum of 50 minutes of training per hour.

"Certification period" means the length of time an EMS provider certificate is valid. The certification period shall be for two years from initial issuance, or renewal, unless specified otherwise on the certificate or unless sooner suspended or revoked.

"Certification status" means a condition placed on an individual certificate for identification as active, deceased, denied, dropped, endorsement, expired, failed, hold, idle, inactive, incomplete, pending, probation, retired, revoked, surrendered, suspended, or temporary.

"Continuing education" means training approved by the department which is obtained by a certified emergency medical care provider to maintain, improve, or expand relevant skills and knowledge and to satisfy renewal of certification requirements.

"Course completion date" means the date of the final classroom session of an emergency medical care provider course.

"Course coordinator" means an individual who has been assigned by the training program to coordinate the activities of an emergency medical care provider course.

"CPR" means training and successful course completion in cardiopulmonary resuscitation and obstructed airway procedures according to recognized national standards. This includes one rescuer, two rescuer, and child/infant cardiopulmonary resuscitation and adult and child/infant obstructed airway procedures.

"Critical care paramedic" means a currently certified paramedic specialist who has successfully completed a critical care course of instruction approved by the department and has received endorsement from the department as a critical care paramedic.

"Current course completion card" means written recognition given for training and successful course completion of CPR or ACLS with an expiration date or a recommended renewal date that exceeds the current date.

"Department" means the Iowa department of public health.

"Director" means the director of the Iowa department of public health.

"DOT" means the United States Department of Transportation.

"Emergency medical care" means such medical procedures as:

1. Administration of intravenous solutions.
2. Intubation.
3. Performance of cardiac defibrillation and synchronized cardioversion.
4. Administration of emergency drugs as provided by rule by the department.
5. Any other medical procedure approved by the department, by rule, as appropriate to be performed by emergency medical care providers who have been trained in that procedure.

"Emergency medical care personnel" or *"provider"* means an individual who has been trained to provide emergency and nonemergency medical care at the first-responder, EMT-basic, EMT-intermediate, EMT-paramedic level or other certification levels adopted by rule by the department and who has been issued a certificate by the department.

"Emergency medical technician-ambulance (EMT-A)" means an individual who has successfully completed, as a minimum, the 1984 United States Department of Transportation's Emergency Medical Technician-Ambulance curriculum, passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-A.

"Emergency medical technician-basic (EMT-B)" means an individual who has successfully completed the current United States Department of Transportation's Emergency Medical Technician-Basic curriculum and department enhancements, passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-B.

"Emergency medical technician-defibrillation (EMT-D)" means an individual who has successfully completed an approved program which specifically addresses manual or automated defibrillation, passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-D.

"Emergency medical technician-intermediate (EMT-I)" means an individual who has successfully completed an EMT-intermediate curriculum approved by the department, passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-I.

"Emergency medical technician-paramedic (EMT-P)" means an individual who has successfully completed the current United States Department of Transportation's EMT-Intermediate curriculum or the 1984 DOT EMT-P curriculum, passed the department's approved written and practical examinations, and is currently certified by the department as an EMT-P.

"Emergency rescue technician (ERT)" means an individual trained in various rescue techniques including, but not limited to, extrication from vehicles and agricultural rescue, and who has successfully completed a curriculum approved by the department in cooperation with the Iowa Fire Service Institute.

"EMS" means emergency medical services.

"EMS advisory council" means a council appointed by the director, pursuant to Iowa Code chapter 147A, to advise the director and develop policy recommendations concerning regulation, administration, and coordination of emergency medical services in the state.

"EMS instructor (EMS-I)" means an individual who has successfully completed an EMS instructor curriculum approved by the department and is currently certified by the department as an EMS-I.

"First responder (FR)" means an individual who has successfully completed the current United States Department of Transportation's first responder curriculum and department enhancements, passed the department's approved written and practical examinations, and is currently certified by the department as an FR.

"First responder-defibrillation (FR-D)" means an individual who has successfully completed an approved program that specifically addresses defibrillation, passed the department's approved written and practical examinations, and is currently certified by the department as an FR-D.

"Hospital" means any hospital licensed under the provisions of Iowa Code chapter 135B.

"ILEECP" means Iowa law enforcement emergency care provider.

"Intermediate" means an emergency medical technician-intermediate.

"NCA" means North Central Association of Colleges and Schools.

"Outreach course coordinator" means an individual who has been assigned by the training program to coordinate the activities of an emergency medical care provider course held outside the training program facilities.

"Paramedic (EMT-P)" means an emergency medical technician-paramedic.

"Paramedic specialist (PS)" means an individual who has successfully completed the current United States Department of Transportation's EMT-Paramedic curriculum or equivalent, passed the department's approved written and practical examinations, and is currently certified by the department as a paramedic specialist.

"Patient" means an individual who is sick, injured, or otherwise incapacitated.

"Physician" means an individual licensed under Iowa Code chapter 148, 150, or 150A.

"Physician assistant (PA)" means an individual licensed pursuant to Iowa Code chapter 148C.

"Physician designee" means a registered nurse licensed under Iowa Code chapter 152, or a physician's assistant licensed under Iowa Code chapter 148C and approved by the board of physician's assistant examiners, who holds a current course completion card in ACLS. The physician designee may act as an intermediary for a supervising physician in directing the actions of emergency medical care personnel in accordance with written policies and protocols.

"Preceptor" means an individual who has been assigned by the training program, clinical facility or service program to supervise students while the students are completing their clinical or field experience. A preceptor must be an emergency medical care provider certified at the level at which the preceptor is providing supervision or higher, or must be licensed as a registered nurse, physician's assistant or physician.

"Primary instructor" means an individual who is responsible for teaching the majority of an emergency medical care provider course.

"Protocols" means written directions and orders established and approved by the service program's medical director that address the procedures to be followed by emergency medical care providers in emergency and nonemergency situations.

"Public access defibrillation (PAD)" means the operation of an automated external defibrillator by a nontraditional provider of emergency medical care.

"Public access defibrillation provider" means someone who has current course completion in a nationally recognized public access defibrillation provider course approved by the department and who also holds a current course completion in CPR. The department deems a provider who has received and maintained certificates of completion from each of these courses to be certified by the department.

"Registered nurse (RN)" means an individual licensed pursuant to Iowa Code chapter 152.

"Service program" or *"service"* means any emergency medical care ambulance service, or nontransport service that has received authorization by the department.

"Service program area" means the geographic area of responsibility served by any given ambulance or nontransport service program.

"Specialty certification" means a nonmedical certification in an area related to emergency medical care including, but not limited to, emergency rescue technician and emergency medical services-instructor.

"Student" means any individual enrolled in a training program and participating in the didactic, clinical, or field experience portions.

"Training program" means an NCA-approved Iowa college, the Iowa law enforcement academy or an Iowa hospital approved by the department to conduct emergency medical care training.

"Training program director" means an appropriate health care professional (full-time educator or practitioner of emergency or critical care) assigned by the training program to direct the operation of the training program.

"Training program medical director" means a physician licensed under Iowa Code chapter 148, 150, or 150A who is responsible for directing an emergency medical care training program.

641—131.2(147A) Emergency medical care providers—requirements for enrollment in training programs. To be enrolled in an EMS training program course leading to certification by the department, an applicant shall:

1. Be at least 17 years of age at the time of enrollment.
2. Have a high school diploma or its equivalent if enrolling in an EMT-I, EMT-P, or paramedic specialist course.
3. Be able to speak, write and read English.
4. Hold a current course completion card in CPR if enrolling in an EMT-B, EMT-I, EMT-P, or paramedic specialist course.
5. Be currently certified, as a minimum, as an EMT-B, if enrolling in an EMT-I, EMT-P, or paramedic specialist course.
6. Be a current EMS provider, RN, PA, or physician and submit a recommendation in writing from an approved EMS training program if enrolling in an EMS instructor course.

641—131.3(147A) Emergency medical care providers—certification, renewal standards, procedures, continuing education, and fees.

131.3(1) *Application and examination.*

a. Applicants shall complete an EMS Student Registration form at the beginning of the course. EMS Student Registration forms are provided by the department.

b. EMS Student Registration forms shall be forwarded to the department by the training program no later than two weeks after the beginning of the course. Courses that are completed within two weeks are exempt from this requirement.

c. Upon satisfactory completion of the course and all training program requirements, including payment of appropriate fees, the student shall be recommended by the training program to take the state-approved certification examinations. Candidates recommended for state certification are not eligible to continue functioning as a student in the clinical and field setting. State certification must be obtained to perform appropriate skills.

d. The practical examination shall be administered using the standards and forms provided by the department. The training program shall notify the department at least four weeks prior to the administration of a practical examination.

e. To be eligible to take the written examination, the student shall first pass the practical examination.

f. Students eligible to take the state written examination shall submit an EMS Certification Application form to the department. EMS Certification Application forms are provided by the department.

g. When a student's EMS Student Registration or EMS Certification Application is referred to the department for investigation, the student shall not be eligible for clinical or field experience, or certification testing until approved by the department.

h. The certifying written examinations shall be administered at times and places determined by the department.

i. No oral certification examinations shall be permitted; however, candidates may be eligible for appropriate accommodations. Contact the Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

j. Practical examination fees shall be determined by the training program.

k. The fee for processing each FR, EMT-B, EMT-I, EMT-P, and paramedic specialist written examination is $20, payable to the Iowa Department of Public Health.

d. Candidates who are unsuccessful by testing may renew under the continuing education standards in subrule 131.3(4); however, renewal must be completed prior to the certificate's expiration date.

e. Candidates who are unsuccessful by testing or who do not complete the continuing education requirements prior to the expiration date shall reinstate an expired certificate pursuant to 131.3(3)*"e"* if active certification is sought.

131.3(6) *Continuing education approval.* The following standards shall be applied when approving continuing education:

a. Required CEHs identified in 131.3(4)*"c"* and 131.3(4)*"d"* shall be approved by an authorized EMS training program or the department using a sponsor number assignment system approved by the department.

b. Optional CEHs identified in 131.3(4)*"e"* and 131.3(4)*"f"* require no formal sponsor number; however, CEHs awarded shall be verified by an authorized EMS training program, a national EMS continuing education accreditation entity, service program medical director, appropriate community sponsor, or the department. Documentation of CEHs awarded shall include program or event, date and title, number of hours approved, and applicable signatures.

131.3(7) *Out-of-state continuing education.* Out-of-state continuing education courses will be accepted for CEHs if they meet the criteria in subrule 131.3(4) and have been approved for emergency medical care personnel in the state in which the courses were held. A copy of course completion certificates (or other verifying documentation) shall, upon request, be submitted to the department with the EMS Affirmative Renewal of Certification Application.

131.3(8) *Fees.* The following fees shall be collected by the department and shall be nonrefundable:

a. FR, EMT-B, EMT-I, EMT-P, and paramedic specialist written examination/certification fee—$20.

b. Renewal of EMT-I, EMT-P, and paramedic specialist certification(s) fee—$10.

c. Endorsement certification fee—$30.

d. Reinstatement fee—$30.

e. Late fee—$30.

f. Inactive or retired certificate—$30.

g. Duplicate/replacement card—$10.

h. Returned check—$20.

131.3(9) *Certification through endorsement.* An individual currently certified by another state or registrant of the National Registry of EMTs must also possess a current Iowa certificate to be considered certified in this state. The department shall contact the state of certification or the National Registry of EMTs to verify certification or registry and good standing. To receive Iowa certification, the individual shall:

a. Complete and submit the EMS Endorsement Application available from the department.

b. Provide verification of current certification in another state or registration with the National Registry of EMTs.

c. Provide verification of current course completion in CPR. Applicants for EMT-P or paramedic specialist endorsement shall also provide verification of current course completion in ACLS.

d. Pass the appropriate Iowa practical and written certification examinations in accordance with subrule 131.3(1) within one year of the department's approval of the endorsement candidate's application. Current National Registry endorsement candidates are exempt from testing.

e. Meet all other applicable eligibility requirements necessary for Iowa certification pursuant to these rules.

f. Submit all applicable fees to the department.

g. An individual certified through endorsement shall satisfy the renewal and continuing education requirements set forth in subrule 131.3(3) to renew Iowa certification.

131.3(10) *Temporary certification through endorsement.* Upon written request, the endorsement applicant may be issued a temporary FR or EMT-B certification by the department. Justification for issuance of the temporary certification must accompany the request. Temporary certification shall not exceed six months per application.

641—131.4(147A) Training programs—standards, application, inspection and approval.

131.4(1) *Curricula.*

a. The training program shall use the following course curricula approved by the department for certification. The department shall determine course length.

(1) EMS provider curricula:

1. PAD—Iowa curriculum or a nationally recognized public access provider AED course approved by the department.
2. ILEECP—Iowa curriculum.
3. First responder—DOT FR curriculum plus department enhancements.
4. EMT-B—DOT EMT-B curriculum plus department enhancements.
5. EMT-I—Iowa curriculum.
6. EMT-P—DOT EMT-I curriculum.
7. Paramedic specialist—DOT EMT-P curriculum.

(2) Specialty curricula:

1. EMS-I—DOT curriculum plus department enhancements.
2. ERT—Iowa curriculum.

Curriculum enhancements are available from the Iowa Department of Public Health, Bureau of EMS, Lucas State Office Building, Des Moines, Iowa 50319-0075.

b. The training program may waive portions of the required EMS provider training for individuals certified or licensed in other health care professions, including, but not limited to, nursing, physician assistant, respiratory therapist, dentistry, and military. The training program shall document equivalent training and what portions of the course have been waived for equivalency.

131.4(2) *Clinical or field experience resources.* If clinical or field experience resources are located outside the framework of the training program, written agreements for such resources shall be obtained by the training program.

131.4(3) *Facilities.*

a. There shall be adequate classroom, laboratory, and practice space to conduct the training program. A library with reference materials on emergency and critical care shall also be available.

b. Opportunities for the student to accomplish the appropriate skill competencies in the clinical environment shall be ensured. The following hospital units shall be available for clinical experience for each training program as required in approved curricula pursuant to subrule 131.4(1):

(1) Emergency department;
(2) Intensive care unit or coronary care unit or both;
(3) Operating room and recovery room;
(4) Intravenous or phlebotomy team, or other method to obtain IV experience;
(5) Pediatric unit;
(6) Labor and delivery suite, and newborn nursery; and
(7) Psychiatric unit.

c. Opportunities for the student to accomplish the appropriate skill competencies in the field environment shall be ensured. The training program shall use an appropriate emergency medical care service program to provide field experience as required in approved curricula pursuant to subrule 131.4(1).

d. The training program shall have liability insurance and shall offer liability insurance to students while they are enrolled in a training program.

131.8(8) Upon receipt of a request for hearing, the request shall be forwarded within five working days to the department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

131.8(9) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

131.8(10) When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 131.8(11).

131.8(11) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

131.8(12) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

a. All pleadings, motions, and rules.

b. All evidence received or considered and all other submissions by recording or transcript.

c. A statement of all matters officially noticed.

d. All questions and offers of proof, objections and rulings on them.

e. All proposed findings and exceptions.

f. The proposed decision and order of the administrative law judge.

131.8(13) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

131.8(14) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

131.8(15) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

131.8(16) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

131.8(17) Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, the news media or employer.

These rules are intended to implement Iowa Code chapter 147A.

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"Intermediate" means an emergency medical technician-intermediate.

"Medical direction" means direction, advice, or orders provided by a medical director, supervising physician, or physician designee (in accordance with written parameters and protocols) to emergency medical care personnel.

"Medical director" means any physician licensed under Iowa Code chapter 148, 150, or 150A who shall be responsible for overall medical direction of the service program and who has completed a medical director workshop, sponsored by the department, within one year of assuming duties.

"Mutual aid" means an agreement, preferably in writing, between two or more services that addresses how and under what circumstances each service will respond to a request for assistance.

"Nonemergency transportation" means transportation that may be provided for those persons determined to need transportation only.

"Nontransport service" means any privately or publicly owned rescue or first response service program which does not provide patient transportation (except when no ambulance is available or in a disaster situation) and utilizes only rescue or first response vehicles to provide emergency medical care at the scene of an emergency.

"Off-line medical direction" means the monitoring of EMS providers through retroactive field assessments and treatment documentation review, critiques of selected cases with the EMS personnel, and statistical review of the system.

"On-line medical direction" means immediate medical advice via radio or phone communications between the EMS provider and the medical director, supervising physician or physician designee.

"PAD liaison" means the individual identified by the nonemergency response agency, public or private, who is responsible for supervision of the agency's PAD program.

"PAD service program" means a nonemergency response business agency, public or private, that has registered with the department to provide automated external defibrillator (AED) coverage.

"Paramedic" means an emergency medical technician-paramedic.

"Paramedic specialist (PS)" means an individual who has successfully completed the current United States Department of Transportation's EMT-Paramedic curriculum or equivalent, passed the department's approved written and practical examinations, and is currently certified by the department as a paramedic specialist.

"Patient" means any individual who is sick, injured, or otherwise incapacitated.

"Physician" means any individual licensed under Iowa Code chapter 148, 150, or 150A.

"Physician assistant (PA)" means an individual licensed pursuant to Iowa Code chapter 148C.

"Physician designee" means any registered nurse licensed under Iowa Code chapter 152, or any physician assistant licensed under Iowa Code chapter 148C and approved by the board of physician assistant examiners, who holds a current course completion card in ACLS. The physician designee may act as an intermediary for a supervising physician in directing the actions of emergency medical care personnel in accordance with written policies and protocols.

"Preceptor" means an individual who has been assigned by the training program, clinical facility or service program to supervise students while the students are completing their clinical or field experience. A preceptor must be an emergency medical care provider certified at the level being supervised or higher, or must be licensed as a registered nurse, physician's assistant or physician.

"Primary response vehicle" means any ambulance, rescue vehicle or first response vehicle which is utilized by a service program and is normally dispatched as the initial vehicle to respond to an emergency call.

"Protocols" means written directions and guidelines established and approved by the service program's medical director that address the procedures to be followed by emergency medical care providers in emergency and nonemergency situations.

"Public access defibrillation (PAD)" means the operation of an automated external defibrillator by a nontraditional provider of emergency medical care.

"Public access defibrillation provider" means someone who has current course completion in a nationally recognized public access defibrillation provider course approved by the department and who also holds a current course completion in CPR.

"Registered nurse (RN)" means an individual licensed pursuant to Iowa Code chapter 152.

"Reportable patient data" means data elements and definitions determined by the department and adopted by reference to be reported to the Iowa EMS service program registry or the trauma registry or a trauma care facility on patients meeting the inclusion criteria.

"Rescue vehicle" means any privately or publicly owned vehicle which is specifically designed, modified, constructed, equipped, staffed and used regularly for rescue or extrication purposes at the scene of a medical or nonmedical emergency.

"Rotorcraft ambulance" means any privately or publicly owned rotorcraft specifically designed, modified, constructed, equipped, staffed and used regularly to transport the sick, injured or otherwise incapacitated who are in need of out-of-hospital emergency medical care or whose condition requires treatment or continuous observation while being transported.

"Secondary response vehicle" means any ambulance, rescue vehicle or first response vehicle which is utilized by a service program when dispatched for routine or convalescent transfers, when the service program's primary response vehicle would have a longer response time, is already in service or is otherwise unavailable or when a mutual aid request requires a different type of response vehicle. Secondary response vehicles may be staffed and equipped at any level up to and including the service program's level of authorization.

"Service program" or *"service"* means any 24-hour emergency medical care ambulance service or nontransport service that has received authorization by the department.

"Service program area" means the geographic area of responsibility served by any given ambulance or nontransport service program.

"Student" means any individual enrolled in a training program and participating in the didactic, clinical, or field experience portions.

"Supervising physician" means any physician licensed under Iowa Code chapter 148, 150, or 150A. The supervising physician is responsible for medical direction of emergency medical care personnel when such personnel are providing emergency medical care.

641—132.2(147A) Authority of emergency medical care personnel.

132.2(1) Emergency medical care personnel shall perform under the supervision of a physician in accordance with Iowa Code chapter 147A and these rules.

132.2(2) An emergency medical care provider may:

a. Render emergency and nonemergency medical care in those areas for which the emergency medical care provider is certified, as part of an authorized service program:

(1) At the scene of an emergency;

(2) During transportation to a hospital;

(3) While in the hospital emergency department;

(4) Until patient care is directly assumed by a physician or by authorized hospital personnel; and

(5) During transfer from one medical care facility to another or to a private home.

641—132.15(147A) Transport options for fully authorized paramedic service programs.

132.15(1) Upon responding to an emergency call, ambulance, or nontransport paramedic level services may make a determination at the scene as to whether emergency medical transportation or nonemergency transportation is needed. The determination shall be made by a paramedic and shall be based upon the nonemergency transportation protocol approved by the service program's medical director. When applying this protocol, the following criteria, as a minimum, shall be used to determine the appropriate transport option:

a. Primary assessment,

b. Secondary assessment (including vital signs and history),

c. Chief complaint,

d. Name, address and age, and

e. Nature of the call for assistance.

Emergency medical transportation shall be provided whenever any of the above criteria indicate that treatment should be initiated.

132.15(2) If treatment is not indicated, the service program may make arrangements for nonemergency transportation. If arrangements are made, the service program shall remain at the scene until nonemergency transportation arrives. During the wait for nonemergency transportation, however, the ambulance or nontransport service may respond to an emergency.

641—132.16(147A) Public access defibrillation. The purpose of this rule is to allow nonemergency response agencies, public or private, to train their employees or associates in the use of the automatic external defibrillator and to provide AED coverage when appropriately trained personnel are available. This rule is intended to enhance and supplement the local EMS system with nontraditional early defibrillation groups/agencies.

132.16(1) *Authority of public access defibrillation provider.* Public access defibrillation providers may perform those skills identified in the public access defibrillation provider curriculum approved by the department.

132.16(2) *Public access defibrillation provider—training requirements.* Public access defibrillation providers shall have current course completion in:

a. Adult CPR, including one rescuer CPR, foreign body airway obstruction, rescue breathing, recovery position, and activating the EMS system; and

b. A nationally recognized AED course approved by the department.

132.16(3) *PAD service program—registration, guidelines, and standards.* A public or private nonemergency response business agency may request to register with the department to provide AED coverage. PAD service programs seeking registration with the department shall:

a. Complete the department's PAD service program registration form.

b. Provide a PAD liaison who shall be responsible for supervision of the PAD service program.

c. Implement a policy for periodic maintenance of the AED.

d. Ensure that the service program's PAD providers maintain AED and CPR skill competency.

e. Identify which authorized Iowa ambulance service program(s) will provide patient transportation.

f. Reregister with the department every five years.

132.16(4) *Complaints and investigations.* Complaints and investigations shall be conducted as with any complaint received against an EMS service program, applying rule 641 IAC 132.10(147A).

These rules are intended to implement Iowa Code chapter 147A.

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*See IAB, Inspections and Appeals Department.

CHAPTER 139
IOWA LAW ENFORCEMENT EMERGENCY CARE PROVIDER

641—139.1(147A) Definitions. For the purpose of these rules, the following definitions shall apply:

"AED" means automated external defibrillator.

"CEHs" means "continuing education hours" which are based upon a minimum of 50 minutes of training per hour.

"Continuing education" means training approved by the department which is obtained by a certified Iowa law enforcement emergency care provider to maintain, improve, or expand relevant skills and knowledge and to satisfy renewal of certification requirements.

"Course completion date" means the date of the final classroom session of an Iowa law enforcement emergency care provider course.

"CPR" means training and successful course completion in cardiopulmonary resuscitation and obstructed airway procedures according to American Heart Association or American Red Cross standards. This includes one rescuer, two rescuer, and child/infant cardiopulmonary resuscitation and adult and child/infant obstructed airway procedures.

"Department" means the Iowa department of public health.

"Director" means the director of the Iowa department of public health.

"EMS" means emergency medical services.

"EMS instructor" means an individual who has successfully completed an EMS instructor curriculum approved by the department, and is currently certified by the department as an EMS-I.

"Iowa law enforcement emergency care provider" means an individual who is certified by the Iowa law enforcement academy as an Iowa peace officer, and has successfully completed an emergency care provider curriculum approved by the department, and who is currently certified by the department as an Iowa law enforcement emergency care provider.

"Law enforcement AED service program" means a recognized Iowa law enforcement agency that has trained its peace officers in the use of an AED and has registered with the department as a law enforcement AED service program.

"Student" means any individual enrolled in a training program and participating in the didactic, clinical, or field experience portions.

"Training program" means an area community college, law enforcement academy or hospital approved by the department to conduct emergency medical care training.

641—139.2(147A) Authority of Iowa law enforcement emergency care provider. Iowa law enforcement emergency care provider may perform skills identified in the Iowa law enforcement emergency care provider curriculum approved by the department, plus the skill of automated defibrillation for which training can be documented.

641—139.3(147A) Iowa law enforcement emergency care providers—requirements for enrollment in training programs. To be enrolled in a training program, an applicant shall:

1. Be at least 18 years of age at the time of enrollment.
2. Have a high school diploma or its equivalent.
3. Be able to speak, write and read English.

641—139.4(147A) Iowa law enforcement emergency care providers—certification, renewal standards and procedures, and fees.

139.4(1) *Application and examination.*

a. Applicants shall complete an EMS student registration form at the beginning of the course. EMS student registration forms are provided by the department.

b. EMS student registration forms shall be forwarded to the department by the training program no later than two weeks after the beginning of the course.

c. Upon satisfactory completion of the course and all training program requirements, including successful completion of the state certifying practical examination, the student shall be recommended by the training program to take the state certification written examinations. Candidates for state certification are not eligible to continue functioning as students in the clinical and field setting. State certification must be obtained to perform appropriate skills.

d. The practical examination shall be administered by the training program using the standards and forms provided by the department. The training program shall notify the department at least two weeks prior to the administration of a practical examination.

e. To be eligible to take the written examination, the student shall first pass the practical examination.

f. The student shall submit an EMS certification application form. EMS certification application forms are provided by the department.

g. When a student's EMS student registration or EMS certification application is referred to the department for investigation, the student shall not be certified until approved by the department.

h. The certifying written examinations shall be administered at times and places determined by the department.

i. No oral certification examinations shall be permitted; however, candidates may be eligible for appropriate accommodations. Contact the Iowa Department of Public Health, Bureau of Emergency Medical Services, Lucas State Office Building, Des Moines, Iowa 50319-0075.

j. Practical examination fees shall be determined by the training program.

k. A student who fails the practical certification examination shall be required to repeat only those stations which were failed and shall have two additional opportunities to attain a passing score. The student may repeat the failed examination stations on the same day as determined by the training program. A student who fails a practical station for the third time shall be required to repeat the entire course in order to be eligible for certification. If a student fails the written examination, the practical examination remains valid for a 12-month period from the date it was successfully completed.

l. A student who fails to attain the appropriate overall score on the written certification examination shall have two additional opportunities to complete the entire examination and attain a passing score. Required overall passing score is 70 percent.

m. All examination attempts shall be completed within one year of the initial course completion date. If an individual is unable to complete the testing within one year due to medical reasons, an extension may be granted upon submission of a signed statement from a physician and approval by the department.

n. Examination scores shall be confidential except that they may be released to the training program which provided the training or released in a manner which does not permit the identification of an individual.

139.4(2) *Renewal of certification.*

a. A certificate shall be valid for two years from issuance unless specified otherwise on the certificate or unless sooner suspended or revoked.

b. All continuing education requirements shall be completed during the certification period prior to the certificate's expiration date. Failure to complete the continuing education requirements prior to the expiration date shall result in an expired certification.

c. The application for renewal of certification shall be submitted to the department within the 90 days prior to the expiration date. Failure to submit a renewal application to the department within the 90 days prior to the expiration date (based upon the postmark date) shall cause the current certification to expire. Iowa law enforcement emergency care providers shall not function on an expired certification.

An individual who completes the required continuing education during the certification period, but fails to submit the application for renewal of certification within 90 days prior to the expiration date, shall be required to submit a late fee of $30 to obtain renewal of certification.

d. An individual who has not completed the required continuing education during the certification period and is seeking to reinstate an expired certificate shall complete a refresher course approved by the department and pass the practical and written certification examinations.

e. If an individual is unable to complete the required continuing education during the certification period due to an illness or injury, an extension of certification may be issued upon submission of a signed statement from a physician and approval by the department.

139.4(3) *Renewal standards.* To be eligible for renewal, the certificate holder shall:

a. Have signed and submitted an application for renewal of certification, provided by the department, within the 90 days prior to the certificate's expiration date.

b. Have a current CPR course completion card or a signed and dated statement from a recognized CPR instructor that documents current course completion in CPR.

c. Have completed four continuing education hours during the certification period including a minimum of one hour in the following topics:

Infectious diseases
Abuse (child and dependent adult)
Trauma emergencies
Medical emergencies

d. Notify the department of a change in address.

e. Maintain a file containing documentation of continuing education hours accrued during each certification period and retain this file for four years from the end of each certification period.

A group of individual certificate holders will be audited for each certification period and will be required to submit verification of continuing education compliance within 45 days of the request. If audited, the following information must be provided: date of program, program sponsor number, title of program, and number of hours approved. Certificate holders audited will be chosen in a random manner or at the discretion of the bureau of EMS. Falsifying reports or failure to comply with the audit request may result in formal disciplinary action.

641—139.5(147A) Training programs.

139.5(1) *Curricula.*

a. The training program shall use the course curricula approved by the department for an Iowa law enforcement emergency care provider and shall include, as a minimum, the following course components:

1. Twenty-four hours of classroom instruction.
2. Practical and written examinations.
3. Clinical and field experience as may be required by the training program.

b. The training program may waive portions of the required training by documenting equivalent training and what portions of the course have been waived for equivalency.

c. An individual currently certified by the department as an emergency medical care provider, pursuant to 641—Chapter 132, may request Iowa law enforcement emergency care provider certification. Such a request must be made in writing to the department with documentation of credentials as an Iowa peace officer.

139.5(2) *Staff.*

a. Course coordinators, outreach course coordinators, and primary instructor(s) used for the Iowa law enforcement emergency care provider course shall be currently certified by the department as EMS instructors.

b. Practical examination evaluators used for the Iowa law enforcement emergency care provider course shall attend a workshop sponsored by the department.

641—139.6(147A) Law enforcement AED service program authorization. A recognized Iowa law enforcement agency that desires to allow its peace officers to use an AED may register with the department to provide AED coverage. The purpose of this rule is to allow law enforcement agencies to train their peace officers in the use of the automated external defibrillator and to provide AED coverage when appropriately trained personnel are available. This rule is intended to enhance and supplement the local EMS system with nontraditional early defibrillation agencies.

139.6(1) Training requirements. Law enforcement personnel wishing to provide AED coverage as part of an Iowa law enforcement agency shall have current course completion in:

a. Adult CPR, including one rescuer CPR, foreign body airway obstruction, rescue breathing, recovery position, and activating the EMS system; and

b. A nationally recognized AED course approved by the department.

139.6(2) Iowa law enforcement AED service program—registration, guidelines, and standards. An Iowa law enforcement agency may register with the department to provide AED coverage. Iowa law enforcement AED service programs seeking registration with the department shall:

a. Complete the department's PAD service program registration form.

b. Provide a PAD liaison who shall be responsible for supervision of the PAD service program.

c. Implement a policy for periodic maintenance of the AED.

d. Ensure that the service program's PAD providers maintain AED and CPR skill competency.

e. Identify which authorized Iowa ambulance service program(s) will provide patient transportation.

f. Reregister with the department every five years.

139.6(3) Complaints and investigations shall be conducted as with any complaint received against an EMS service program, applying rule 641 IAC 132.10(147A).

These rules are intended to implement Iowa Code chapter 147A.

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MASSAGE THERAPISTS

CHAPTER 130
MASSAGE THERAPISTS

645—130.1(152C) Definitions. For the purpose of these rules, the following definitions apply:

"Board" means the board of examiners for massage therapy.

"Department" means the department of public health.

"Massage therapist" means a person licensed to practice the health care service of the healing art of massage therapy.

"Massage therapy" means performance for compensation of massage, myotherapy, massotherapy, bodywork, bodywork therapy, superficial hot and cold applications, vibration and topical applications, or other therapy which involves manipulation of the muscle and connective tissue of the body, excluding osseous tissue, to treat the muscle tonus system for the purpose of enhancing health, providing muscle relaxation, increasing range of motion, reducing stress, relieving pain, or improving circulation.

"Reciprocal license," for the purposes of this chapter, means that an applicant has been licensed under laws of another jurisdiction and has applied for a license from the state of Iowa.

645—130.2(152C) Description and organization of the board.

130.2(1) The board is composed of seven persons appointed by the governor as follows:

a. Four members shall be massage therapists.

b. Three members who are not licensed massage therapists shall be representatives of the general public.

130.2(2) The board shall have the duties and responsibilities as outlined in Iowa Code chapters 130, 272C, 17A, 21, 22, 68B, and section 69.15.

130.2(3) Organization. Annually, the board shall elect a chairperson, vice-chairperson and secretary and establish standing committees as needed from its membership.

130.2(4) Meetings. The board shall:

a. Hold special meetings called by the chairperson or upon the request by four members of the board to the chairperson or board administrator. Special meetings may be held by electronic means in accordance with Iowa Code section 21.8.

b. Make available to the public the date, time, and location of board meetings. Specific information may be obtained from the Board Administrator, Professional Licensure Division, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

c. Make available to the public the date that board materials are due in the board office for the agenda of regularly scheduled meetings. Materials received two weeks prior to a scheduled board meeting shall be placed on the agenda. Materials from emergency or unusual circumstances may be added to the agenda with the chairperson's approval.

d. Hold meetings that are open to the public.

(1) Anyone who has submitted materials for the agenda or who has requested to be present shall be given the opportunity to address the board.

(2) At every regularly scheduled board meeting, time shall be designated for public comment.

(3) Anyone who has not asked to address the board during public comment may be recognized by the chairperson. Acknowledgment and an opportunity to speak shall be at the discretion of the chairperson.

e. Conduct meetings following Robert's Rules of Order.

f. Conduct business only if a quorum is present. A majority of this board shall constitute a quorum.

645—130.3(152C) Availability of forms. Copies of all forms and information may be obtained by writing to the Iowa Board of Massage Therapy Examiners, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

645—130.4(152C) Requirements for licensure. All persons acting or serving in the capacity of a massage therapist shall hold a massage therapist's license issued by the board.

130.4(1) All applications must be made on forms supplied by the Massage Therapy Office, Professional Licensure Division, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

130.4(2) Application requirements are as follows:

a. Initial licensure. Applicants shall submit all of the following:

(1) A completed application form and the certificate of diploma from a board-approved school;

(2) The required license fee as stated in rule 130.7(152C);

(3) An official transcript sent directly from the school(s) to the board office; and

(4) Proof of passing the National Certification Examination for Therapeutic Massage and Bodywork administered by the testing service contracting with the National Certification Board for Therapeutic Massage and Bodywork. Proof of passing must be sent directly from the testing service to the division of professional licensure. The passing score on the written examination shall be the passing point criterion established by the national testing authority at the time the test was administered.

b. Licensure of a licensee from another state. A licensee from another state seeking a license to practice massage therapy in Iowa will be considered on an individual basis. The applicant shall submit:

(1) An official copy of the license with the application;

(2) Verification of the license to practice massage therapy issued by the other state(s);

(3) A statement from the licensing board(s) of the other state(s) outlining the licensure requirements of that state;

(4) A certified copy of scores from the appropriate professional examination to be sent to the board, if applicable; and

(5) The required fee as stated in rule 130.7(152C).

c. Temporary licensure of a licensee from another state. A licensee from another state with license requirements less stringent than those of Iowa shall submit:

(1) An official copy of the license with the application;

(2) Verification of the license to practice massage therapy issued by the other state(s);

(3) A statement from the licensing board(s) of the other state(s) outlining the licensure requirements of that state;

(4) A certified copy of scores from the appropriate professional examination to be sent to the board, if applicable;

(5) The required fee as stated in rule 130.7(152C).

The individual shall receive a temporary license that shall be valid for a period of up to one year and may not be renewed.

d. The board may consider applications on a case-by-case basis which do not appear on their face to meet requirements if the requirements may be alternatively satisfied by demonstrated equivalency. The burden shall be on the applicant to document that the applicant's education and experience are substantially equivalent to the requirements which may be alternatively satisfied.

645—130.5(152C) Requirements for approval of massage therapy education curriculum.

130.5(1) An application for schools providing massage therapy education curriculum shall be made in writing to the Massage Therapy Office, Professional Licensure Division, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075. Application forms shall be obtained from the office. A request for massage therapy education curriculum approval may be made by an applicant for a license who has graduated from the school or by the management of the school.

130.5(2) Approval may be granted by the board if the curriculum satisfies the following:

a. It requires completion of at least 500 hours of instructor-supervised, in-classroom academic instruction. The curriculum must include 100 hours of anatomy and physiology and 400 hours of other subjects relating directly to the development of skills, knowledge and attitudes necessary to render competent professional massage therapy to the public including basic first aid and cardiopulmonary resuscitation (CPR).

b. Student clinic hours shall be at the school site, shall be supervised by a qualified instructor and shall not exceed 20 percent of the actual curriculum hours.

c. Field experience hours, if required by the school, shall be documented, but may not be included as part of the 500 hours of instructor-supervised, in-classroom academic instruction.

d. All course instructors must be listed in an attachment to the application, along with their credentials, professional training and proof of at least one year's experience in the subject they are to teach.

e. The entire school curriculum and class schedule must be submitted with the application and shall document the hours of each subject taught. The curriculum required for students who graduated prior to July 1, 1993, will require only 100 hours of anatomy and physiology and 400 hours of other subjects.

f. A school's curriculum shall be approved if it met the above requirements at the time that the applicant for license graduated.

g. If an approved school alters its curriculum from that submitted and approved by more than 25 percent of total course hours, it must submit those changes to the board for approval prior to implementation.

h. Course content of an approved curriculum must be accurately stated in all promotional materials.

i. Should the board find that an approved curriculum school is not providing the courses and hours it has submitted on its application, the board may revoke, suspend or put on probation approval of the school's curriculum. Revocation will be for a minimum of six consecutive months from the date of determined noncompliance. At the end of the revocation period, the school may reapply for approval of a massage therapy program according to the rules in effect at the time of the reapplication.

j. All approved schools providing massage therapy curriculum which operate within the state of Iowa must update their existing applications to be in compliance with this rule. The board will notify all approved schools providing massage therapy curriculum within four weeks after this rule is adopted. Schools will have four months from the date of notification to submit the necessary documentation to verify compliance.

645—130.6(152C) License renewal.

130.6(1) The biennial license shall be renewed every two years on the anniversary date of the original license. Those originally licensed in the even year will renew in the even year; those licensed in the odd year will renew in the odd year. The continuing education period shall run concurrently with each renewal period.

130.6(2) Licensees who have met continuing education requirements for the biennium and wish to have their licenses renewed shall complete the board-approved renewal form and the board-approved continuing education report and return them to professional licensure, department of public health.

130.6(3) Late filing. Licensees who fail to submit the application for renewal and complete and appropriately document continuing education hours by their anniversary date of each renewal biennium shall be required to pay a late filing fee and may be subject to an audit of their continuing education report.

130.6(4) Licensees who have not fulfilled the requirements for license renewal or placed the license on inactive status by 30 days after their anniversary date of the licensure biennium will have a lapsed license and shall not engage in the practice of massage therapy.

130.6(5) Rescinded IAB 12/4/96, effective 1/8/97.

645—130.7(152C) License fees. All fees are nonrefundable.

130.7(1) Rescinded IAB 12/4/96, effective 1/8/97.

130.7(2) The fee for a temporary reciprocal license issued for up to one year is $100.

130.7(3) Rescinded IAB 12/4/96, effective 1/8/97.

130.7(4) The fee for a license to practice massage therapy issued on the basis of examination or endorsement is $100.

130.7(5) The renewal fee of a license to practice for a biennial period is $100.

130.7(6) Penalty fee for failure to complete and return the renewal application is $25.

130.7(7) Penalty fee for failure to complete the required continuing education is $25. Failure to complete and return the continuing education report is $25.

130.7(8) Reinstatement fee is $25.

130.7(9) Fee for certified statement that a licensee is licensed in Iowa is $10.

130.7(10) Fee for failure to report, change of address within 30 days is $10.

130.7(11) Fee for failure to report, in writing, change of name within 30 days is $10.

130.7(12) Fee for a returned check is $15.

645—130.8(152C) Transition provisions. Prior to July 1, 2002, an applicant shall complete the following for:

130.8(1) *Initial licensure.*

a. Be required to pass the board-approved national certification examination;

b. Pay the applicable licensing fee; and

c. Not be required to meet the completion of curriculum of massage therapy requirements contained in Iowa Code section 152C.3, subsection 1, paragraph *"a."*

130.8(2) *Lapsed license.*

a. Applicants with a license that has lapsed prior to July 1, 2000, who apply for reinstatement prior to July 1, 2002, shall be required to complete a reinstatement application and pay a renewal fee and reinstatement fee pursuant to Iowa Code section 147.11 and section 147.80, subsection 26. Penalty fees otherwise incurred pursuant to Iowa Code section 147.10, and continuing education requirements applicable to the period prior to licensure reinstatement, shall be waived by the board; or

b. Applicants with a license that has lapsed prior to July 1, 2000, who do not apply for reinstatement prior to July 1, 2002, shall be required to apply for reinstatement in accordance with lapsed license reinstatement provisions established by rule 645—132.6(152C).

645—130.9(152C) Reinstatement of lapsed licenses. Rescinded IAB 10/4/00, effective 11/8/00.

These rules are intended to implement Iowa Code chapter 152C.

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CHAPTER 131
DISCIPLINARY PROCEDURES FOR MASSAGE THERAPISTS

645—131.1(152C) Discipline. For all acts and offenses listed in this rule, the board may impose any of the disciplinary methods outlined in Iowa Code section 272C.3(2)*"a"* to *"f"* including the imposition of a civil penalty which shall not exceed $1000. The board may discipline a licensee for any of the following reasons:

131.1(1) All grounds listed in Iowa Code section 147.55 which are:

a. Fraud in procuring a license.

b. Professional incompetence.

(1) A substantial lack of knowledge or ability to discharge professional obligations within the scope of the licensee's practice; or

(2) A willful or repeated departure from, or the failure to conform to, the minimal standard of accepted or prevailing practice.

c. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

d. Habitual intoxication or addiction to the use of drugs.

e. Conviction of a felony related to the profession or occupation of the licensee or the conviction of a felony that would affect the licensee's ability to practice within a profession which includes, but is not limited to, a felonious act which is so contrary to honesty, justice or good morals and so reprehensible as to violate the public confidence and trust imposed upon the licensee.

f. Fraud in representations as to skill or ability.

g. Use of untruthful or improbable statements in advertisements.

h. Willful or repeated violations of the provisions of Iowa Code chapter 147.

(1) Violation of the rules promulgated by the board.

(2) Violation of the terms of a decision and order issued by the board.

(3) Violation of the terms of a settlement or agreement entered into and issued by the board.

(4) Personal disqualifications.

1. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

2. Involuntary commitment for the treatment of mental illness, drug addiction or alcoholism.

(5) Practicing the profession while the license is under suspension, lapsed or delinquent for any reason.

(6) Suspension or revocation of license by another state.

(7) Negligence by the licensee in the practice of the profession, which is a failure to exercise due care including negligent delegation to or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

(8) Prohibited acts consisting of the following:

1. Permitting an unlicensed employee or person under the licensee's control to perform activities requiring a license.

2. Permitting another person to use the licensee's license for any other purpose.

3. Practicing outside the scope of a license.

4. Obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority; or selling, prescribing, giving away, or administering controlled substances.

5. Verbally or physically abusing clients.

6. Making suggestive, lewd, lascivious, or improper remarks or advances to a client.

7. Engaging in sexual conduct with regard to a client, including but not limited to inappropriate physical conduct or any behavior that is seductive, demeaning, or exploitive.

8. Engaging in any sexual intimidation or sexual relationship involving a client.

9. Being adjudged mentally incompetent by a court of competent jurisdiction.

10. Permitting a licensed person under the licensee's control to practice outside the scope of the person's license.

131.1(2) Unethical business practices, consisting of any of the following:

a. False or misleading advertising.

b. Betrayal of a professional confidence.

c. Promotion for personal gain of an unnecessary drug, device, treatment, procedure, or service (directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from a person, place, facility, or business in which the licensee has a financial interest).

d. Failure to report a change of name or mailing address.

e. Failure to submit continuing education certificate with license renewal by date due for the renewal year.

f. Failure to complete the required continuing education within the compliance period.

g. Submission of a false report of continuing education, or failure to submit the annual report of continuing education.

h. Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action.

i. Failure to comply with a subpoena issued by the board.

j. Failure to report to the board any violation of the reasons for a disciplinary action as listed in this rule by another licensee.

k. Failure to pay any civil penalties assessed pursuant to the rules.

l. Failure to submit curriculum changes.

645—131.2(152C) Civil penalties.

131.2(1) Civil penalties may be imposed upon a person or business that employs an individual who is not licensed as a massage therapist. Civil penalties may be imposed upon a person or business that employs an individual who uses the initials "L.M.T." or the words "licensed massage therapist," "massage therapist," "masseur," or "masseuse," or any other words or titles which imply or represent that the employed person practices massage therapy but is not licensed as a massage therapist. Failure to follow the above may result in:

a. A civil penalty not to exceed $1000 on a person or business that violates this rule:

(1) Each violation is a separate offense.

(2) Each day a continued violation occurs after citation by the board is a separate offense with the maximum penalty not to exceed $10,000;

b. The board's inspection of any facility which advertises or offers services purporting to be delivered by massage therapists;

c. A citation being sent to the alleged violator by certified mail, return receipt requested; and

d. The board's consideration of the following in determining civil penalties:

(1) Whether the amount imposed will be a substantial economic deterrent to the violation.

(2) The circumstances leading to or resulting in the violation.

(3) The severity of the violation and the risk of harm to the public.

(4) The economic benefits gained by the violator as a result of noncompliance.

(5) The welfare or best interest of the public.

131.2(2) Civil penalties may be imposed upon a person who is practicing as a massage therapist without a license. Civil penalties may be imposed upon a person who practices as an individual and uses the initials "L.M.T." or the words "licensed massage therapist," "massage therapist," "masseur," or "masseuse," or any other words or titles which imply or represent that the person practices massage therapy but is not licensed as a massage therapist. A person must be licensed as a massage therapist to practice in this state as a massage therapist. Failure to follow the above may result in:

a. A civil penalty not to exceed $1000 on a person who violates this rule:

(1) Each violation is a separate offense.

(2) Each day a continued violation occurs after citation by the board is a separate offense with the maximum penalty not to exceed $10,000;

b. The board's inspection of any facility which advertises or offers services purporting to be delivered by massage therapists;

c. A citation being sent to the alleged violator by certified mail, return receipt requested;

d. The board's consideration of the following in determining civil penalties:

(1) Whether the amount imposed will be a substantial economic deterrent to the violation.

(2) The circumstances leading to or resulting in the violation.

(3) The severity of the violation and the risk of harm to the public.

(4) The economic benefits gained by the violator as a result of noncompliance.

(5) The welfare or best interest of the public.

131.2(3) Issuing an order or citation.

a. The board shall provide a written notice and the opportunity to request a hearing on the record.

b. The hearing must be requested within 30 days of the issuance of the notice and shall be conducted according to Iowa Code chapter 17A.

c. The board may, in connection with a proceeding under this subrule, issue subpoenas to require the attendance and testimony of witnesses and the disclosure of evidence and may request the attorney general to bring an action to enforce the subpoena.

131.2(4) Judicial review.

a. A person aggrieved by the imposition of a civil penalty under this rule may seek a judicial review in accordance with Iowa Code section 17A.19.

b. The board shall notify the attorney general of the failure to pay a civil penalty within 30 days after entry of an order or within 10 days following final judgment in favor of the board if an order has been stayed pending appeal.

c. The attorney general may commence an action to recover the amount of the penalty, including reasonable attorney fees and costs.

d. An action to enforce an order under this rule may be joined with an action for an injunction.

131.2(5) A person is not in violation of the statute or rules if that person practices massage therapy for compensation while in attendance at a school offering a curriculum meeting the requirements of rule 645—130.5(152C) and is under the supervision of a member of the school's faculty.

645—131.3(152C) Reporting continuing education credits. Rescinded IAB 10/4/00, effective 11/8/00.

645—131.4(152C) Hearings. Rescinded IAB 10/4/00, effective 11/8/00.

645—131.5(152C) Disability or illness. Rescinded IAB 10/4/00, effective 11/8/00.

645—131.6 to **131.17** Reserved.

645—131.18(152C) Civil penalty for employment of person not licensed. Rescinded IAB 10/4/00, effective 11/8/00.

645—131.19(152C) Civil penalty for use of title. Rescinded IAB 10/4/00, effective 11/8/00.

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CHAPTER 132
CONTINUING EDUCATION FOR MASSAGE THERAPISTS

645—132.1(152C) Definitions. For the purpose of these rules, the following definitions shall apply:

"Active license" means the license of a person who is acting, functioning, and working in compliance with license requirements.

"Administrator" means the administrator of the board of examiners for massage therapy.

"Approved program/activity" means a continuing education program/activity meeting the standards set forth in these rules, which has received advance approval by the board pursuant to these rules.

"Approved sponsor" means a person or an organization sponsoring continuing education activities that has been approved by the board as a sponsor pursuant to these rules. During the time an organization, educational institution, or person is an approved sponsor, all continuing education activities of such organization, educational institution, or person may be deemed automatically approved.

"Audit" means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period or the selection of providers for verification of adherence to continuing education provider requirements during a specified time period.

"Board" means the board of examiners for massage therapy.

"Continuing education" means planned, organized learning acts acquired during initial licensure designed to maintain, improve, or expand a licensee's knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

"Hour of continuing education" means a clock hour spent by a licensee in actual attendance at and completion of an approved continuing education activity.

"Inactive license" means the license of a person who is not engaged in practice in the state of Iowa.

"Lapsed license" means a license that a person has failed to renew as required, or the license of a person who has failed to meet stated obligations for renewal within a stated time.

"License" means license to practice.

"Licensee" means any person licensed to practice as a massage therapist in the state of Iowa.

645—132.2(152C) Continuing education requirements.

132.2(1) The biennial continuing education compliance period shall be run concurrently with each renewal period. Each biennium, each person who is licensed to practice as a licensee in this state shall be required to complete a minimum of 12 hours of continuing education approved by the board.

132.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 12 hours of continuing education per biennium for each subsequent license renewal.

132.2(3) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be approved by the board or otherwise meet the requirements herein and be approved by the board pursuant to statutory provisions and the rules that implement them.

132.2(4) No hours of continuing education shall be carried over into the next biennium.

132.2(5) It is the responsibility of each licensee to finance the cost of continuing education.

645—132.3(152C) Standards for approval.

132.3(1) *General criteria.* A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if it is determined by the board that the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program. The application must be 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 the qualifications of presenters;

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

(1) Date, location, course title, presenter(s);

(2) Number of program contact hours (One contact hour equals one hour of continuing education credit.); and

(3) Official signature or verification by program sponsor.

132.3(2) *Specific criteria.*

a. A licensee may obtain continuing education hours of credit by attending:

(1) Programs listed but not limited to: hydrotherapy; superficial hot and cold applications; vibration and topical applications; contraindications; pathology; HIV/AIDS education. Also included is therapy which involves manipulation of the muscle and connective tissue of the body to treat the muscle tonus system for the purpose of enhancing health, providing muscle relaxation, increasing range of motion, reducing stress, relieving pain, or improving circulation.

(2) Courses on herbology, aromatherapy, homeopathy and other similar areas are eligible for approval only if they specifically teach topical application techniques for professional practitioners. Only the number of hours spent on teaching, explaining or demonstrating topical application are eligible for continuing education credit and must be specifically described and scheduled in the continuing education program application.

(3) Continuing education activities of an approved sponsor.

b. The maximum number of hours in each category in each biennium is as follows:

(1) Two hours of credit per biennium may be granted for each of the following topics: professional ethics; CPR/first aid.

(2) Six hours of credit per biennium may be granted for home study courses, which include written and electronically transmitted material or video, if the following criteria are met:

1. There is an approved sponsoring person, group or agency;
2. The program meets all the criteria set forth in standards for approval of continuing education;
3. The program is accompanied by a certificate of postcourse testing which includes the participant's examination score and the passing examination score; and
4. The program is accompanied by a certificate of completion which includes:

- Course title;
- Date of completion;
- Number of program hours; and
- Verification that the course was conducted by home study delivery.

c. Unacceptable subject matter may include but is not limited to: meditation, feng shui, personal development, practice management, communication, government regulation, insurance, collective bargaining, community service presentations or courses that do not deal with manipulation. Courses about energy-based techniques performed without physical manipulation of tissue are not eligible for approval.

645—132.4(152C) Approval of sponsors, programs, and activities for continuing education.

132.4(1) *Approval of sponsors.* An applicant who desires approval as a sponsor of courses, programs, or other continuing education activities shall, unless exempted elsewhere in these rules, apply for approval to the board on the form designated by the board stating the applicant's educational history for the preceding two years or proposed plan for the next two years.

a. The form shall include the following:

(1) Date(s), location, course title(s) offered and program description;

(2) Total hours of instruction presented;

(3) Names and qualifications of instructors including résumés or vitae; and

(4) Evaluation form(s).

b. Records shall be retained by the sponsor for four years.

c. Attendance record report. The person or organization sponsoring an approved continuing education activity shall provide a certificate of attendance or verification to the licensee providing the following information:

(1) Program date(s);

(2) Course title and presenter;

(3) Location;

(4) Number of clock hours attended and continuing education hours earned;

(5) Name of sponsor and sponsor number;

(6) Licensee's name; and

(7) Method of presentation.

d. All approved sponsors shall maintain a copy of the following:

(1) The continuing education activity;

(2) List of enrolled licensees' names and license numbers; and

(3) Number of continuing education clock hours awarded for a minimum of four years from the date of the continuing education activity.

e. The sponsor shall submit a report of all continuing education programs conducted in the previous year during the assigned month for reporting designated by the board. The report shall include:

(1) Date(s), location, course title(s) offered and outline of content;

(2) Total hours of instruction presented;

(3) Names and qualifications of instructors including résumés or vitae;

(4) Evaluation form(s); and

(5) A summary of the evaluations completed by the licensees.

132.4(2) *Prior approval of programs/activities.* An organization or person other than an approved sponsor that desires prior approval of a course, program or other educational activity or that desires to establish approval of such activity prior to attendance shall apply for approval to the board on a form provided by the board at least 60 days in advance of the commencement of the activity. The board shall approve or deny such application in writing within 30 days of receipt of such application. The application shall state:

a. The date(s);

b. Course(s) offered;

c. Program description;

d. Total hours of instruction; and

e. Names and qualifications of speakers and other pertinent information.

The organization or person shall be notified of approval or denial by ordinary mail.

132.4(3) *Review of programs.* Continuing education programs/activities shall be reported every year at the designated time assigned by the board. The board may at any time reevaluate an approved sponsor or program. If, after reevaluation, the board finds there is cause for revocation of the approval of an approved sponsor, the board shall give notice of the revocation to that sponsor by certified mail. The sponsor shall have the right to hearing regarding the revocation. The request for hearing must be sent within 20 days after the receipt of the notice of revocation. The hearing shall be held within 90 days after the receipt of the request for hearing. The board shall give notice by certified mail to the sponsor of the date set for the hearing at least 30 days prior to the hearing. The board shall conduct the hearing in compliance with rule 645—11.9(17A).

132.4(4) *Postapproval of activities.* A licensee seeking credit for attendance and participation in an educational activity which was not conducted by an approved sponsor or otherwise approved shall submit to the board, within 60 days after completion of such activity, the following:

a. The date(s);
b. Course(s) offered;
c. Program description;
d. Total hours of instruction and credit hours requested;
e. Names and qualifications of speakers and other pertinent information;
f. Request for credit which includes a brief summary of the activity; and
g. Certificate of attendance or verification.

Within 90 days after 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. A licensee not complying with the requirements of this subrule may be denied credit for such activity.

132.4(5) *Voluntary relinquishment.* The approved sponsor may voluntarily relinquish sponsorship by notifying the board office in writing.

645—132.5(152C) Reporting continuing education by licensee. At the time of license renewal, each licensee shall be required to submit a report on continuing education to the board on a board-approved form.

132.5(1) The information on the form shall include:

a. Title of continuing education activity;
b. Date(s);
c. Sponsor of the activity;
d. Board-approved sponsor number;
e. Number of continuing education hours earned; and
f. Teaching method used.

132.5(2) Audit of continuing education report. After each educational biennium, the board will audit a percentage of the continuing education reports before granting the renewal of licenses to those being audited.

a. The board will select licensees to be audited.

b. The licensee shall make available to the board for auditing purposes a copy of the certificate of attendance or verification for all reported activities that includes the following information:

(1) Date, location, course title, schedule (brochure, pamphlet, program, presenter(s)), and method of presentation;

(2) Number of contact hours for program attended; and

(3) Indication of the successful completion of course.

c. For auditing purposes, the licensee must retain the above information for two years after the biennium has ended.

d. Submission of a false report of continuing education or failure to meet continuing education requirements may cause the license to lapse and may result in formal disciplinary action.

e. All renewal license applications that are submitted late (after the end of the compliance period) may be subject to audit of the continuing education report.

f. Failure to receive the renewal application shall not relieve the licensee of responsibility of meeting continuing education requirements and submitting the renewal fee by the end of the compliance period.

645—132.6(152C) Reinstatement of lapsed license. Failure of the licensee to renew within 30 days after expiration date shall cause the license to lapse. A person who allows the license to lapse cannot engage in practice in Iowa without first complying with all regulations governing reinstatement as outlined in the board rules. A person who allows the license to lapse may apply to the board for reinstatement of the license. Reinstatement of the lapsed license may be granted by the board if the applicant:

1. Submits a written application for reinstatement to the board;
2. Pays all of the renewal fees then due;
3. Pays all penalty fees which have been assessed by the board for failure to renew;
4. Pays reinstatement fee;
5. Provides evidence of satisfactory completion of continuing education requirements during the period since the license lapsed. The total number of continuing education hours required for license reinstatement is computed by multiplying 12 by the number of bienniums since the license lapsed to a maximum of five bienniums or 60 continuing education hours; and
6. If the license has lapsed for more than five bienniums, the licensee shall complete the National Certification Examination for Therapeutic Massage and Bodywork successfully within one year immediately prior to the submission of such application for reinstatement.

645—132.7(152C,272C) Continuing education waiver for active practitioners. A massage therapist licensed to practice massage therapy shall be deemed to have complied with the continuing education requirements of this state during the period that the licensee serves honorably on active duty in the military services or as a government employee outside the United States as a practicing massage therapist.

645—132.8(152C,272C) Continuing education exemption for inactive practitioners. A licensee who is not engaged in practice in the state of Iowa may be granted an exemption of continuing education 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 of massage therapy in Iowa without first complying with all regulations governing reinstatement after exemption. The application for a certificate of exemption shall be submitted upon forms provided by the board. The licensee shall have completed the required continuing education at the time of reinstatement.

645—132.9(152C,272C) Continuing education waiver for disability or illness. The board may, in individual cases involving disability or illness, grant waivers of the minimum educational 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 therefor is made on forms provided by the board and signed by the licensee and appropriate licensed health care practitioners. The board may grant waiver of the minimum educational requirements for any period of time not to exceed one calendar year from the onset of disability or illness. In the event that the disability or illness upon which a waiver has been granted continues beyond the period of waiver, the licensee must reapply 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—132.10(152C,272C) Reinstatement of inactive practitioners. Inactive practitioners who have been granted a waiver of compliance with these rules and obtained a certificate of waiver shall, prior to engaging in the practice of massage therapy in the state of Iowa, satisfy the following requirements for reinstatement.

132.10(1) Submit written application for reinstatement to the board upon forms provided by the board with appropriate reinstatement fee; and

132.10(2) Furnish in the application evidence of one of the following:

a. Satisfactory completion of continuing education requirements during the period since the license became inactive. The total number of continuing education hours required for license reinstatement is computed by multiplying 12 by the number of bienniums since the license lapsed to a maximum of five bienniums or 60 continuing education hours.

b. Successful completion of the National Certification Examination for Therapeutic Massage and Bodywork within one year immediately prior to the submission of such application for reinstatement.

645—132.11(272C) Hearings. In the event of denial, in whole or part, of any application for approval of a continuing education program or credit for continuing education activity, the applicant, licensee or program provider shall have the right within 20 days after the sending of the notification of denial by ordinary mail to request a hearing which shall be held within 90 days after receipt of the request for hearing. The hearing shall be conducted by the board or an administrative law judge designated by the board, in substantial compliance with the hearing procedure set forth in rule 645—11.9(17A).

These rules are intended to implement Iowa Code section 272C.2, chapter 152C as amended by 2000 Iowa Acts, Senate File 2113, and chapter 272C.

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CHAPTERS 133 to 135
Reserved

CHAPTER 136
PETITIONS FOR RULE MAKING
Rescinded IAB 7/14/99, effective 8/18/99

CHAPTER 137
DECLARATORY RULINGS
Rescinded IAB 7/14/99, effective 8/18/99

CHAPTER 138
AGENCY PROCEDURE FOR RULE MAKING
Rescinded IAB 7/14/99, effective 8/18/99

CHAPTER 139
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
Rescinded IAB 7/14/99, effective 8/18/99

NURSING BOARD[655]

[Prior to 8/26/87, see Nursing, Board of[590], renamed Nursing Board[655] under the "umbrella" of Public Health Department by 1986 Iowa Acts, ch 1245]

CHAPTER 1
ADMINISTRATIVE AND REGULATORY AUTHORITY

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b. Two years of experience in clinical nursing.

c. Two years of experience in nursing education.

d. The applicable academic qualifications:

(1) Heads of programs who are employed on July 1, 1992, shall be considered adequately prepared as long as they remain in that position.

(2) Heads of programs who are hired after July 1, 1992, shall have a master's or doctoral degree with a major in nursing at either level at the time of hire. The date of hire is the first day employed with compensation at a particular nursing education program.

e. Preparation in education or administration.

f. In addition to the above:

(1) Programs offering the baccalaureate and higher degrees in nursing.

1. A doctoral degree with a nursing major at the baccalaureate, master's, or doctoral level.
2. Two years of experience in nursing education at the baccalaureate level or higher.

(2) Programs offering formal advanced practice education in nursing.

1. Education equal to this program offering.
2. Two years of clinical experience in the specialty area.

g. Submission of a detailed description of qualifications to the board office. A program head appointed after July 1, 1992, shall submit a detailed description of qualifications by which the individual's compliance with this subrule can be determined. This information shall be submitted within one month of appointment.

h. The nursing education programs in the community colleges shall have one designated head of the program per community college district.

i. The head of a program shall be responsible for the administration of the program.

655—2.4(152) Resources of the controlling institution.

2.4(1) The controlling institution is responsible for provision of resources adequate to meet program needs.

a. Human resources.

(1) Head of program.

(2) Faculty.

(3) Secretarial and other support and staff services to ensure appropriate use of faculty time and expertise.

b. Physical resources.

(1) Classrooms, conference rooms, laboratories, offices, and equipment.

(2) Student facilities.

c. Library resources. Adequate and accessible holdings and space.

2.4(2) The agencies and services utilized for learning experiences are adequate in number and kind to meet program objectives.

655—2.5(152) Curriculum.

2.5(1) The curriculum, a program of study developed by the faculty, shall:

a. Reflect the philosophy, organizing framework, purpose, and objectives of the program.

b. Identify the terminal behavioral outcomes.

c. Be in accordance with current educational, societal, and nursing standards.

d. Be consistent with the laws governing the practice of nursing.

e. Ensure sufficient preparation for the safe and effective practice of nursing.

f. Include teaching/learning experiences and learning strategies selected to meet curriculum objectives.

g. When offered within a college or university:

(1) Be comparable to the quality and requirements of other degree programs within that institution.

(2) Be planned within the college calendar.

(3) Assign credit hours for lecture and clinical or laboratory experience comparable with the college pattern.

2.5(2) Curricula for practical nursing programs shall include didactic content and practice in nursing with a focus on supportive and restorative health care for individuals through the life span.

a. Didactic content shall include life sciences, behavioral sciences, legal and ethical aspects as related to the role of the practical nurse, medical nursing, surgical nursing, maternity nursing, nursing of children, and gerontological nursing.

b. Learning experiences shall include care during acute, episodic, and chronic illnesses; observation; communication; technical skills; equipment use; and problem solving.

2.5(3) Curricula for basic nursing education programs shall include didactic content and practice in nursing which focuses on attaining, maintaining, and regaining health for individuals and groups throughout the life span.

a. Didactic content shall include content in nursing of clients with medical-surgical therapies, nursing of childbearing and childrearing families, mental health nursing, and nursing through the aging process. Baccalaureate programs shall include nursing research and nursing in the community.

b. Learning experiences shall include care during acute, episodic, and chronic illnesses with emphasis given to health promotion, illness prevention, and rehabilitative intervention.

c. Content in history and trends as related to nursing and professional, legal, and ethical aspects of nursing.

d. Content in the principles of leadership, management, and patient education.

e. Supporting content from the biological-physical, behavioral/social sciences.

2.5(4) Curricula for programs granting a baccalaureate degree to registered nurses shall include didactic content and practice in nursing which will enable the student to achieve competencies comparable to outcomes of baccalaureate education.

2.5(5) Curricula for programs granting a master's degree to registered nurses shall include didactic content and practice in nursing which will enable the student to achieve competencies comparable to outcomes of baccalaureate education and master's education.

2.5(6) Curricula of formal advanced practice education programs in nursing shall:

a. Provide advanced didactic content and practice in a specialty area of nursing.

b. Address the role of advanced registered nurse practitioners.

2.5(7) Curricula of master's and doctoral nursing degree programs shall:

a. Provide for the in-depth study of nursing science including theory, clinical, and research components.

b. Provide for the study in role areas such as nursing education, administration, or clinical practice.

655—2.6(152) Faculty.

2.6(1) Faculty requirements for programs are as follows:

a. There shall be a sufficient number of adequately prepared faculty to meet program objectives. Adequately prepared shall mean:

(1) A head of the program who is hired after July 1, 1992, shall have a master's or doctoral degree with a major in nursing at either level at the time of hire.

(2) A faculty member who is hired after July 1, 1992, shall meet the requirements set forth in subrule 2.6(2).

(3) Faculty members and heads of programs employed on July 1, 1992, shall be considered adequately prepared as long as they remain in that position.

b. Written personnel policies and position descriptions shall be provided.

c. A faculty development program shall be designed to further the competence of individual faculty members and the faculty as a whole.

d. There shall be a written teaching load policy.

e. There shall be a nursing faculty organization which shall operate according to written bylaws and meet on a regular basis. Minutes shall be recorded and available for reference.

f. In practical and basic nursing programs a ratio of one faculty to a maximum of ten students shall be required in those practice situations involving direct patient care.

2.6(2) Requirements of faculty members who teach nursing are as follows:

a. Current licensure as a registered nurse in Iowa. Individuals are currently licensed when licensed in another state and recognized for licensure in this state, pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8.

b. Two years of experience in clinical nursing.

c. The applicable academic qualifications:

(1) A faculty member who is hired to teach in a basic RN program after July 1, 1992, shall have at least a baccalaureate degree with a major in nursing or an applicable field at the time of hire. This person shall make annual progress toward the attainment of a master's or doctoral degree with a major in nursing or an applicable field. One degree shall be in nursing.

1. Applicable fields include but are not limited to education, counseling, psychology, sociology, health education, health administration, public health. One who wishes to fulfill this requirement with education in an applicable field not listed may petition the board for a determination of applicability.

2. The date of hire is the first day employed with compensation at a particular nursing education program.

3. Annual progress shall mean a minimum of one course per year taken as part of an organized plan of study.

(2) A faculty member who is hired to teach after July 1, 1992, in a practical nursing program or the first level of an associate degree nursing program with a ladder concept shall have a baccalaureate or higher degree in nursing or an applicable field at the time of hire. The date of hire is the first day employed with compensation at a particular nursing education program.

(3) A registered nurse hired to teach in a master's program shall hold a master's or doctoral degree with a major in nursing at the time of hire. A registered nurse teaching in a clinical specialty area shall hold a master's degree with a major in nursing, advanced level certification by a national professional nursing organization approved by the board in the clinical specialty area in which the individual teaches, and current registration as an advanced registered nurse practitioner according to the laws of the state(s) in which the individual teaches. Faculty preparation at the doctoral or terminal degree level shall be consistent with the mission of the program.

(4) Those faculty hired only to teach in the clinical setting shall be exempted from subparagraphs (1) and (2) if the faculty member is closely supervised to ensure proper integration of didactic content into the clinical setting. If hired after July 1, 1992, those hired to teach only in the clinical setting shall have a baccalaureate degree in nursing or an applicable field, or shall make annual progress toward the attainment of such a degree. Annual progress shall mean a minimum of one course per year taken as part of an organized plan of study. The date of hire is the first day employed with compensation at a particular nursing education program.

(5) The head of a program may petition the board for a waiver from the requirements in subrules 2.3(2), 2.6(1), paragraph *"a,"* and 2.6(2). The board shall require the program to demonstrate its efforts and progress in meeting these requirements. The board, if it determines a waiver is warranted because of unusual or unforeseen circumstances, shall issue a waiver for a limited period of time and may indicate conditions which must be met.

d. Submission of a detailed description of qualifications to the board office.

(1) Each program head shall submit a list of all faculty teaching on July 1, 1992, along with a detailed description of qualifications by which each faculty member's compliance with this subrule can be determined. The list shall be submitted within one month of notification by the board of this requirement. The detailed description of each faculty member's qualifications shall be submitted within another month.

(2) The board shall monitor each program's progress in meeting this subrule at least annually in the annual reports.

2.6(3) Functions of faculty.

a. Develop, implement, and evaluate the purpose, philosophy, and objectives of the program.
b. Design, implement, evaluate, and revise the curriculum.
c. Provide students with the written policies as specified in subrule 2.7(1).
d. Participate in academic advising and guidance of students.
e. Provide for admission, promotion, and graduation of students.
f. Provide for student, self, and peer evaluation of teaching effectiveness.
g. Participate in activities to improve competency in area of responsibility.

655—2.7(152) Program responsibilities.

2.7(1) *Policies affecting students.* Programs shall include provisions for the development, implementation, and communication of the following student policies:

a. Admission/enrollment. Licensure if applicable according to 655—subrule 3.2(1).
b. Transfer or readmission.
c. Withdrawal.
d. Progression.
e. Grading system.
f. Suspension or dismissal.
g. Graduation.
h. Holiday and leave of absence.
i. Health.
j. Counseling.
k. Grievance procedure.

i. Curriculum plan.

j. Descriptions of resources, clinical facilities, preceptorship experiences, and contractual arrangements.

k. Copy of audited fiscal reports, including a statement of income and expenditures.

l. Goals for present academic year.

m. Program catalog.

2.11(2) *Special reports.* The program shall notify the board of the following:

a. Change of controlling institution. Information shall include official names of the programs and controlling institution, organizational chart of the controlling institution, and names of administrative officials.

b. Changes in administrative personnel in the program or the controlling institution.

c. Opening of a new site or campus.

2.11(3) *Changes requiring board approval.*

a. These changes require the submission of eight copies of the proposed change at least three weeks prior to the next regularly scheduled board meeting and include but need not be limited to the following:

(1) Changes in the curriculum which lengthen or shorten the program.

(2) Addition or deletion of clinical or didactic credit hours in a course.

(3) Changes in course requirements for graduation.

b. Changes requiring the submission of one copy of the proposed change. A board representative shall review the proposed change for approval. If the change is not approved, seven additional copies shall be requested and the matter shall be submitted for board approval. These changes include but need not be limited to the following:

(1) Changes in the philosophy, objectives, or organizing framework used to define the curriculum.

(2) Change in the predominant method of instruction (e.g., where a course taught by faculty is shifted to computer, programmed self-study, or correspondence).

(3) Rearrangement of the sequence of required courses.

These rules are intended to implement Iowa Code section 152.5 and 2000 Iowa Acts, House File 2105.

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CHAPTER 3
LICENSURE TO PRACTICE
REGISTERED NURSE/LICENSED PRACTICAL NURSE

[Prior to 5/23/84, IAC, appeared as separate Chapters 3 and 4]
[Prior to 8/26/87, Nursing Board[590] Ch 3]

655—3.1(17A,147,152,272C) Definitions.

Accredited or approved nursing program. An accredited or approved nursing program means a nursing education program whose status has been recognized by the board or by a similar board in another state that prepares individuals for licensure as a licensed practical nurse, registered nurse, or registration as an advanced registered nurse practitioner; or grants a baccalaureate, master's, or doctorate degree with a major in nursing.

Applicant. Applicant means a person who is qualified to take the examination or apply for licensure.

Delinquent licensee. Delinquent licensee means a registered nurse/licensed practical nurse who has failed to renew the license or place it on inactive status as provided by subrule 3.7(5) by the fifteenth day of the month following the expiration date.

Endorsement. Endorsement means the process by which a registered nurse/licensed practical nurse licensed in another state becomes licensed in Iowa.

Examination. Examination means any of the tests used to determine minimum competency prior to the issuance of a registered nurse/licensed practical nurse license.

Fees. Fees means those fees collected which are based upon the cost of sustaining the board. The nonrefundable fees set by the board are as follows:

1. For the original license based on the registered nurse examination, $75.
2. For the original license based on the practical nurse examination, $75.
3. For a registered nurse/licensed practical nurse license by endorsement, $101.
4. For registration as an advanced registered nurse practitioner, $21 per year, or any portion thereof.
5. For a certified statement that a registered nurse/licensed practical nurse is licensed in this state or registered as an advanced registered nurse practitioner, $25.
6. For reactivation of a license to practice as a registered nurse/licensed practical nurse, based on $27 per year, or any portion thereof, totals $81 for a license lasting more than 24 months up to 36 months.
7. For the renewal of a license to practice as a registered nurse/licensed practical nurse, $81 for a three-year period.
8. For a duplicate or reissued license/original certificate to practice as a registered nurse/licensed practical nurse, or registration card/original certification to practice as an advanced registered nurse practitioner, $20.
9. For a registered nurse/licensed practical nurse late renewal, $50, plus the renewal fee as specified in paragraph "6" of this rule.
10. For a registered nurse/licensed practical nurse delinquent license fee, $100, plus all renewal fees to date due, the total back renewal fees shall not exceed $250.

11. For a check returned for any reason, $15. If licensure/registration had been issued by the board office based on a check for the payment of fees and the check is later returned by the bank, the board shall request payment by certified check or money order. If the fees are not paid within two weeks of notification by certified mail of the returned check, the license/registration is no longer in effect. The licensee's status returns to what it would have been had this license/registration not been issued.

12. For a copy of the Law of Iowa as it Pertains to the Practice of Nursing, $2.

13. For a copy of the Iowa Administrative Code, Nursing Board[655], $2.

14. For a certified copy of an original document, $20.

15. Reserved.

16. For special licensure, $62.

17. For a subscription to Notices of Intended Action for the period July 1 to June 30, $25 or for the period January 1 to June 30, $12.50.

Inactive licensee. Inactive licensee means a registered nurse/licensed practical nurse who has requested to be placed on inactive status.

Lapsed license. A lapsed license means an expired license which is either late or delinquent.

Late licensee. Late licensee means a registered nurse/licensed practical nurse who has failed to renew the license or place it on inactive status as provided by subrule 3.7(5) by the expiration date on the license. The time between the expiration date and the fifteenth day of the month following the expiration date is considered a grace period or late period.

NCLEX. NCLEX means National Council Licensure Examination, the currently used examination.

Overpayment. Overpayment means any overpayment of fees less than $10 received by the board that shall not be refunded.

Reactivation. Reactivation means that process whereby an inactive licensee obtains a current license.

Reinstatement. Reinstatement means that process by which a delinquent licensee obtains a current license.

Temporary license. Temporary license means a license issued on a short-term basis for a specified time pursuant to subrule 3.5(3).

Verification. Verification means that process whereby the board will provide a certified statement that a registered nurse/licensed practical nurse is licensed, inactive, or lapsed, or an advanced registered nurse practitioner is registered in this state.

This rule is intended to implement Iowa Code section 147.80.

655—3.2(17A,147,152,272C) Mandatory licensure.

3.2(1) A person who practices nursing in the state of Iowa as defined in Iowa Code section 152.1, outside of one's family, shall have a current Iowa license, whether or not the employer is in Iowa and whether or not the person receives compensation. The nurse shall maintain a copy of the license and shall have it available for inspection when engaged in the practice of nursing in Iowa.

a. A person denied licensure or not having a current active Iowa license because of disciplinary action by the board, or having an encumbered license in another state, may not take a nursing course with a clinical component.

b. A nurse who has been licensed in another country and does not hold a current active license because of disciplinary action may not take a nursing course with a clinical component.

3.2(2) Current Iowa licensure is mandatory except when:

a. A nurse who resides in another party state is recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8. The nurse shall maintain a copy of the license and shall have it available for inspection when engaged in the practice of nursing in Iowa.

b. A nurse who resides out of state, holds an active out-of-state license, and provides only intermittent consultation which shall not include patient care.

c. A nurse who holds an active license in another state provides services to patients in Iowa only during interstate transit.

d. A nurse who holds an active license in another state provides emergency services while serving on a Red Cross disaster team.

e. A nurse who holds an active license in any state or who has completed a nursing education course of study in another country provides nursing services incidental to a course of study while enrolled in an approved nursing education program.

This rule is intended to implement Iowa Code section 147.2.

655—3.3(17A,147,152,272C) Qualifications for licensure.

3.3(1) Applicants shall meet the requirements as set forth in Iowa Code sections 147.3 and 152.7.

a. Graduation from an accredited high school or its equivalent prior to the examination. High school equivalency shall be in conformity with the requirements of the department of education, state of Iowa.

b. Graduation from an approved nursing program as defined in Iowa Code section 152.5(1) or completion of a course of study as defined in Iowa Code section 152.7(3), prior to the examination. Theory and clinical experience shall be completed before the examination and shall include medical nursing, surgical nursing, obstetric nursing, and nursing of children. In addition, registered nurse applicants shall have had theory and clinical experience in psychiatric nursing prior to the examination.

c. Passing the examination by the standards determined by the board.

d. Approval by the board of those with a past felony record. The board determines the eligibility for licensure of a felony applicant on the felony's relationship to nursing.

3.3(2) Exceptions to the qualifications for licensure. Applicants for licensure in Iowa must meet the qualifications in effect in Iowa at the time of the applicant's graduation from nursing school. The relevant requirements listed in subrule 3.3(1) are subject to the following exceptions:

a. Graduation from high school or its equivalent was not required of registered nurse applicants until 1930 or of licensed practical nurse applicants until 1963.

b. If graduation from a nursing program was prior to 1952, a license will be granted according to board-approved guidelines.

c. Registered nurse graduates prior to 1951 are not required to have psychiatric nursing or be tested in psychiatric nursing.

d. A person licensed as a registered nurse in another state by waiver shall be accepted for Iowa licensure only if the waiver period corresponds to that in Iowa.

e. Exceptions related to examinations:

(1) Before 1946, the registered nurse applicant shall have passed a written test prepared by a licensing board of another state.

(2) A practical nurse applicant must have written the same examination as that administered in Iowa and achieved a score established as passing for that test by the board unless the applicant was graduated and licensed prior to July 1951.

(3) After June 1976, an applicant who took the State Board Test Pool Examination (SBTPE) shall have passed that examination within four writings in order to be eligible for an Iowa license. Prior to that date, there was no limit on the number of writings. An applicant who failed the SBTPE but wrote it less than four times is eligible to take the NCLEX an unlimited number of times.

(4) An applicant whose national examination scores do not meet the Iowa requirements in effect at the time of the examination and who wishes to become licensed in Iowa shall appeal to the board. The board may require the applicant to produce evidence of working experience or successful completion of a refresher course. The board may require the applicant to rewrite the current examination.

This rule is intended to implement Iowa Code sections 147.2 and 152.7(3).

655—3.4(17A,147,152,272C) Licensure by examination.

3.4(1) *Qualifications for licensure by examination.* Applicants shall meet qualifications for licensure as set forth in subrule 3.3(1).

3.4(2) *Examination.* The board contracts with the National Council of State Boards of Nursing, Inc., to utilize the examination.

a. The passing standard for the examination is determined by the board.

(1) NCLEX-PN results will be reported to the candidates as pass or fail.

(2) NCLEX-RN results will be reported to the candidates as pass or fail.

b. The examination shall be administered in Iowa.

c. The examination shall be administered in accordance with the manual prepared by the National Council of State Boards of Nursing, Inc., for the administration of the NCLEX.

d. The candidate shall present identification for admission to the testing center in accordance with the policies of the National Council of State Boards of Nursing, Inc.

e. Licensure examination statistics are available to the public.

3.4(3) *Application—Iowa graduates.* Application for licensure by examination to practice as a registered nurse in Iowa shall be made according to the following process.

a. The board is responsible for the following:

(1) At least twice a year, the board staff shall request the head of each nursing program in Iowa to submit information about the students who are anticipated to complete the program.

(2) Upon return of the information about the students who are anticipated to complete the program, an adequate supply of application forms and instructions for filing shall be sent to the head of the nursing program.

(3) The board shall confirm or deny the eligibility of each applicant upon receipt of the following materials:

Completed application form (submitted by the applicant).

Original license fee (submitted by the applicant).

Notification of completion of the NCLEX registration process (confirmed by NCLEX).

Official nursing transcript denoting the date of entry and date of graduation from an approved nursing education program.

b. An applicant who has graduated from an approved registered nurse program and has failed NCLEX-RN is eligible to take the NCLEX-RN an indefinite number of times.

c. An applicant who has graduated from an approved practical nurse program and has failed the State Board Test Pool Examination less than four times is eligible to take the NCLEX-PN an indefinite number of times.

d. An applicant who has graduated from an approved registered nurse program and has failed the State Board Test Pool Examination less than four times is eligible to take the NCLEX-RN an indefinite number of times.

e. An applicant who fails the examination shall be required to refile the following before taking another examination:

(1) The board application form.

(2) The original license fee.

(3) The NCLEX registration.

(4) The NCLEX registration fee.

3.4(9) *Certificate of licensure by examination.* Upon completion of the relevant qualifications for licensure by examination defined in these rules, the board shall issue a certificate of licensure by examination and a current license to practice as a registered nurse/licensed practical nurse.

a. A licensee shall use the relevant title registered nurse/licensed practical nurse and relevant initials R.N./L.P.N.

b. A licensee is required to hold a certificate and license. If a certificate or license is stolen or lost, the licensee shall apply for a duplicate as specified in subrule 3.7(7).

This rule is intended to implement Iowa Code sections 147.36, 147.80, 152.7(3), and 152.9.

655—3.5(17A,147,152,272C) Licensure by endorsement.

3.5(1) *Qualifications for licensure by endorsement.* The endorsee must meet the qualifications for licensure defined in subrule 3.3(1).

3.5(2) *Applicants currently licensed in another state.* Application for licensure to practice as a registered nurse or licensed practical nurse by endorsement shall be made according to the following process:

a. The board is responsible for the following:

(1) Upon request, application forms and instructions shall be sent to the applicant.

(2) Evaluation of credentials to determine that the applicant has met all qualifications for licensure.

(3) Issuance of an original certificate and current license to practice following determination of eligibility and upon receipt of the following materials:

Completed application form (submitted by the applicant).

Endorsement fee (submitted by the applicant).

Official nursing transcript denoting date of entry and date of graduation (submitted by the nursing program).

Verification of licensure form (submitted by state of original licensure).

b. The applicant is responsible for the following:

(1) Submission of a completed board application form.

(2) Submission of the endorsement fee, made payable to the Iowa Board of Nursing. The fee, as outlined in rule 3.1(17A,147,152,272C) is not refundable.

(3) Having the nursing program forward an official nursing transcript which denotes the date of entry and date of graduation.

(4) Submission of the verification of licensure form from the original state of licensure.

(5) Submission of evidence attesting that Iowa is the primary state of residence if the applicant is changing primary state of residence from another party state as outlined in rule 655—16.2(152).

(6) Submission of the above documents within 12 months from the date of receipt of the written request. The board reserves the right to destroy the documents after 12 months.

c. A license shall not be issued to an applicant whose license is under sanction by another state without approval of the board.

d. An applicant for endorsement who has had disciplinary action in another state shall submit all the materials required for endorsement and appear before the board. The board shall review the reasons for the out-of-state sanction and determine whether to grant licensure in Iowa. The board may determine special conditions for licensure.

e. A license shall not be issued to an applicant who fails to complete the application process within the allotted time. A license shall be issued when the application process is complete.

3.5(3) *Temporary license.* A temporary license shall be issued to an applicant who is licensed in another state if the applicant meets the qualifications for licensure as outlined in subrule 3.3(1) and has applied for licensure as a registered nurse/licensed practical nurse in Iowa. The board application form and endorsement fee as outlined in rule 3.1(17A,147,152,272C) and verification of licensure form shall be on file in the office of the board prior to the issuance of the temporary license.

a. A temporary licensee may use the appropriate title of registered nurse or licensed practical nurse and the appropriate abbreviation R.N. or L.P.N.

b. The temporary license must be signed by the licensee to be valid. The temporary license shall be issued for a period of 30 days. A second temporary license may be issued for a period not to exceed 30 days or at the discretion of the executive director.

c. A temporary license shall not be issued to an applicant whose license is under sanction by another state without approval of the board. The board may determine special conditions for licensure.

d. A temporary license shall not be issued to an applicant who fails to complete the application process within the allotted time. A license shall be issued when the application process is complete.

3.5(4) *Certificate of licensure by endorsement.* Upon completion of the endorsement procedures defined in these rules, the board shall issue a certificate of licensure by endorsement and a current license to practice as a registered nurse/licensed practical nurse. If a certificate or license is stolen or lost, the licensee shall apply for a duplicate as specified in subrule 3.7(7).

This rule is intended to implement Iowa Code sections 147.2 and 152.9.

655—3.6(17A,147,152,272C) Special licensure.

3.6(1) *Special licensure by endorsement.* A short-term special license may be granted by the board on an individual basis. The intent of the special license is to allow nurses licensed in a nonparty state to be licensed and to practice in Iowa for a fixed period of time and only under certain conditions. The purpose of the license is to allow those nurses not previously licensed in Iowa to provide care in a specialty area, to provide consultation or teaching where care is directed, or to obtain clinically based continuing education.

The application process for those currently licensed in a nonparty state who are eligible for endorsement is as follows:

a. Upon request the board shall send the application form and instructions to the applicant.

b. The application shall include identifying information, history of felony conviction, history of any disciplinary action or pending action against the individual's nursing license in another state, reason and circumstances surrounding the request for special endorsement.

c. The applicant shall submit the completed application form, special licensure fee as designated in rule 3.1(17A,147,152,272C), and evidence of current, active licensure in another state.

d. The board staff shall determine the validity of the request for special licensure by endorsement based on the duration, location, and need for the short-term nursing license and the absence of sanctions against the applicant's current license and absence of any felony convictions.

(1) If the application is incomplete, the board staff shall return it to the applicant.

(2) If the application shows a previous felony conviction or any disciplinary action or pending action against the individual's nursing license, the board staff shall return the application with an explanation that the applicant is not eligible for special licensure by endorsement. The applicant may be eligible for regular licensure by endorsement according to rule 3.5(17A,147,152,272C). The board staff shall send the regular endorsement application to the individual.

(3) If the application is complete and the request is valid, the board staff shall send the information to the board for its review.

(4) The board shall review the need for the special license by endorsement.

1. If the board determines the need exists for special licensure by endorsement, it shall grant a license. The license shall indicate its special nature and the duration and location for which it can be used. The period of licensure by special endorsement shall be determined by the board. Upon written request extensions may be granted by the board. A second special license by endorsement shall not be issued to the same person. A person with need for repeated special licensure may seek a waiver of this restriction.

2. If the board denies special licensure by endorsement, the individual may still be eligible for regular licensure by endorsement according to rule 3.5(17A,147,152,272C). The regular endorsement application shall be sent to the individual along with a reason for the denial of special licensure by endorsement.

e. This special licensure by endorsement shall be subject to all rules and regulations promulgated by the board except those pertaining to:

(1) Verification.
(2) Reactivation.
(3) Inactivation.
(4) Renewal.
(5) Late renewal.
(6) Continuing education requirements.

3.6(2) *Special licensure for those licensed in another country.* A special license may be granted by the board on an individual basis. The intent of the special license is to allow nurses licensed in another country who are not eligible for endorsement to practice in Iowa for a fixed period of time and only under certain conditions. The purpose of the license is to allow those nurses not previously licensed in Iowa to provide care in a specialty area, to provide consultation or teaching where care is directed to serve as a research assistant, to serve as a teaching assistant or to obtain clinically based continuing education.

a. Upon request the board shall send the application form and instructions to the applicant or sponsor.

b. The application shall include identifying information, history of felony conviction, history of licensure in any other state, and reason and circumstances surrounding the request for special licensure.

c. The applicant shall submit the completed application form, special licensure fee as designated in subrule 3.1(6), and a certificate by the Commission on Graduates of Foreign Nursing Schools (CGFNS), or evidence of a score of at least 500 on the Test of English as a Foreign Language (TOEFL).

d. The board staff shall determine the validity of the request for special licensure based on the duration, location, and need for the nursing license and absence of any felony convictions.

(1) If the application is incomplete, the board staff shall return it to the applicant.

(2) If the application shows a previous felony conviction, the board staff shall return the application with an explanation that the applicant is not eligible for special licensure. The applicant may be eligible for licensure by examination according to subrule 3.4(6). The board shall send the application for individuals educated in another country to the individual.

e. The board shall review the need for a special license.

(1) If the board determines the need exists for special licensure, it shall grant a license. The license shall indicate its special nature and the duration and location for which it can be used. The period of special licensure shall be determined by the board. Upon written request extensions may be granted by the board. A second special license will not be issued to the same person. A person with need for repeated special licensure may seek a waiver of this restriction.

(2) If the board denies a license, the individual may be eligible for licensure by examination according to subrule 3.4(6).

f. This special licensure shall be subject to all rules and regulations promulgated by the board except those pertaining to:

(1) Verification.
(2) Reactivation.

(2) An inactive licensee shall have completed 15 contact hours of continuing education as specified in 655—Chapter 5. The continuing education shall have been earned within the 12 months prior to reactivation.

(3) The reactivation fee is specified in rule 3.1(17A,147,152,272C).

(4) Upon receipt of the completed application, required continuing education materials, and fee, the board shall issue a current license to practice in Iowa. The license shall be issued for more than 24 months up to 36 months until the license can be placed in the three-year renewal cycle based on birth month. Expiration shall be on the fifteenth day of the birth month.

3.7(7) *Duplicate license or certificate.* The board shall issue a duplicate of a current license or original certificate upon written request of the licensee and payment of the fee specified in rule 3.1(17A,147,152,272C). If the current license is destroyed, lost, or stolen, a duplicate license is required as replacement.

3.7(8) *Reissue of a license.* If there is an error on the license or certificate made by the board office, no fee shall be charged for a reissued corrected license or certificate. A license may be reissued if a licensee desires to have a current name or address printed on the current license prior to renewal. Reissuance is optional; however, written notification to the board office of name or address change is mandatory as outlined in subrule 3.7(1). The board shall reissue a license per written request of the licensee and payment of the fee as specified in rule 3.1(17A,147,152,272C) or at the direction of the executive director.

655—3.8(17A,147,152,272C) Verification. Upon written request from the licensee or other state and payment of the verification fee as specified in rule 3.1(17A,147,152,272C), the board shall provide a certified statement to another state that a registered nurse/licensed practical nurse is licensed, inactive, or lapsed in Iowa.

These rules are intended to implement Iowa Code chapters 17A, 152, and 272C and Iowa Code sections 147.2, 147.10, 147.11, 147.36, 147.76, 147.80, 147.100, 152.1, 152.5, 152.9, and 152.10 and 2000 Iowa Acts, House File 2105.

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CHAPTER 4
DISCIPLINE

[Prior to 5/23/84, IAC, "Disciplinary Proceedings" appeared as Ch 8]
[Prior to 5/23/84, "Licensure to Practice—Licensed Practical Nurse" appeared as Ch 4. See Ch 3.]
[Prior to 8/26/87, Nursing Board[590] Ch 4]

655—4.1(17A,147,152,272C) Board authority. The board of nursing may discipline a registered nurse, a licensed practical nurse or an advanced registered nurse practitioner for any grounds stated in Iowa Code chapters 147, 152 and 272C, or rules promulgated thereunder.

655—4.2(17A,147,152,272C) Complaints and investigations. Complaints are allegations of wrongful acts or omissions relating to the ethical or professional conduct of a licensee.

4.2(1) In accordance with Iowa Code section 272C.3(1)"*c*," the board shall investigate or review, upon written complaint or upon its own motion pursuant to other information received by the board, alleged acts or omissions which the board reasonably believes constitute cause for licensee discipline.

4.2(2) The executive director or authorized designee shall investigate complaints in order to determine the probability that a violation of law or rule has occurred.

655—4.3(17A,147,152,272C) Issuance of investigatory subpoenas. The board shall have the authority to issue an investigatory subpoena in accordance with the provisions of Iowa Code section 17A.13.

4.3(1) The executive director or designee may, upon the written request of a board investigator or on the executive director's own initiative, subpoena books, papers, records and other real evidence which are necessary for the board to decide whether to institute a contested case proceeding. In the case of a subpoena for mental health records, each of the following conditions shall be satisfied prior to the issuance of the subpoena:

a. The nature of the complaint reasonably justifies the issuance of a subpoena;

b. Adequate safeguards have been established to prevent unauthorized disclosure;

c. An express statutory mandate, articulated public policy, or other recognizable public interest favors access; and

d. An attempt was made to notify the patient and to secure an authorization from the patient for release of the records at issue.

4.3(2) A written request for a subpoena or the executive director's written memorandum in support of the issuance of a subpoena shall contain the following:

a. The name and address of the person to whom the subpoena will be directed;

b. A specific description of the books, papers, records or other real evidence requested;

c. An explanation of why the documents sought to be subpoenaed are necessary for the board to determine whether it should institute a contested case proceeding; and

d. In the case of a subpoena request for mental health records, confirmation that the conditions described in subrule 4.3(1) have been satisfied.

4.3(3) Each subpoena shall contain the following:

a. The name and address of the person to whom the subpoena is directed;

b. A description of the books, papers, records or other real evidence requested;

c. The date, time and location for production or inspection and copying;

d. The time within which a motion to quash or modify the subpoena must be filed;

e. The signature, address and telephone number of the executive director or designee;

f. The date of issuance;

g. A return of service.

4.3(4) Any person who is aggrieved or adversely affected by compliance with the subpoena and who desires to challenge the subpoena must, within 14 days after service of the subpoena, or before the time specified for compliance if such time is less than 14 days, file with the board a motion to quash or modify the subpoena. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

4.3(5) Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to issue a decision or the board may issue a decision. Oral argument may be scheduled at the discretion of the board or the administrative law judge. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

4.3(6) A person aggrieved by a ruling of an administrative law judge who desires to challenge that ruling must appeal the ruling to the board by serving on the executive director, either in person or by certified mail, a notice of appeal within ten days after service of the decision of the administrative law judge.

4.3(7) If the person contesting the subpoena is not the person under investigation, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board's decision is not final for purposes of judicial review until either (1) the person is notified that the investigation has been concluded with no formal action, or (2) there is a final decision in the contested case.

655—4.4(17A,147,152,272C) Board action. The board shall review investigative conclusions and do one of the following:

1. Close the investigative case without action.
2. Request further inquiry.
3. Appoint a peer review committee to assist with the investigation.
4. Determine the existence of sufficient probable cause and order a disciplinary hearing to be held in compliance with Iowa Code section 272C.6.

655—4.5(17A,147,152,272C) Peer review committee. The board may establish a peer review committee to assist with the investigative process when deemed necessary.

4.5(1) The committee shall determine if the conduct of the licensee conforms to minimum standards of acceptable and prevailing practice of nursing and submit a report of its findings to the board.

4.5(2) The board shall review the committee's findings and proceed with action available under rule 4.4(17A,147,152,272C).

4.5(3) The peer review committee shall observe the confidentiality requirements imposed by Iowa Code section 272C.6.

655—4.6(17A,147,152,272C) Grounds for discipline. The board may discipline a licensee for wrongful acts or omissions related to nursing practice, licensure or unprofessional conduct and may revoke, suspend or deny issuance or renewal of licensure upon receipt of a certificate of noncompliance pursuant to Iowa Code chapters 252J and 261.

4.6(1) In accordance with Iowa Code section 147.55(1), behavior which constitutes fraud in procuring a license may include, but need not be limited to, the following:

a. Falsification of the application, credentials, or records submitted to the board for licensure as a registered nurse, licensed practical nurse, or registration as an advanced registered nurse practitioner.

b. Fraud, misrepresentation, or deceit in taking the licensing examination or in obtaining a license as a registered nurse, licensed practical nurse, or registration as an advanced registered nurse practitioner.

c. Impersonating any applicant in any examination for licensure as a registered nurse or licensed practical nurse.

4.6(2) In accordance with Iowa Code section 147.55(2), professional incompetency may include, but need not be limited to, the following:

a. Lack of knowledge, skill, or ability to discharge professional obligations within the scope of nursing practice.

b. Deviation by the licensee from the standards of learning, education, or skill ordinarily possessed and applied by other nurses in the state of Iowa acting in the same or similar circumstances.

c. Willful or repeated departure from or failure to conform to the minimum standards of acceptable and prevailing practice of nursing in the state of Iowa.

d. Willful or repeated failure to practice nursing with reasonable skill and safety.

e. Willful or repeated failure to practice within the scope of current licensure or level of preparation.

f. Failure to meet the standards as defined in 655—Chapter 6, Iowa Administrative Code.

g. Failure to comply with the requirements of Iowa Code chapter 139C.

4.6(3) In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes knowingly making misleading, deceptive, untrue, or fraudulent representations in the practice of a profession may include, but need not be limited to, the following:

a. Oral or written misrepresentation relating to degrees, credentials, licensure status, records and applications.

b. Falsifying records related to nursing practice or knowingly permitting the use of falsified information in those records.

4.6(4) In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but need not be limited to, the following:

a. Performing nursing services beyond the authorized scope of practice for which the individual is licensed or prepared.

b. Allowing another person to use one's nursing license for any purpose.

c. Improper delegation of nursing services, functions, or responsibilities.

d. Committing an act or omission which may adversely affect the physical or psychosocial welfare of the patient or client.

e. Committing an act which causes physical, emotional, or financial injury to the patient or client.

f. Engaging in sexual conduct, including inappropriate physical contact or any behavior that is seductive, demeaning, or exploitative, with regard to a patient or client.

4.23(4) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the board 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.

4.23(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 the United States mail or state interoffice mail.

(Date) (Signature)

655—4.24(17A) Discovery.

4.24(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.

4.24(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 4.24(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

4.24(3) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

655—4.25(17A,272C) Issuance of subpoenas in a contested case.

4.25(1) Subpoenas issued in a contested case may compel the attendance of witnesses at deposition or hearing and may compel the production of books, papers, records, and other real evidence. A command to produce evidence or to permit inspection may be joined with a command to appear at deposition or hearing or may be issued separately. Subpoenas may be issued by the executive director or designee upon written request. A request for a subpoena of mental health records must confirm that the conditions described in subrule 4.3(1) have been satisfied prior to the issuance of the subpoena.

4.25(2) A request for a subpoena shall include the following information, as applicable, unless the subpoena is requested to compel testimony or documents for rebuttal or impeachment purposes:

a. The name, address and telephone number of the person requesting the subpoena;

b. The name and address of the person to whom the subpoena shall be directed;

c. The date, time and location at which the person shall be commanded to attend and give testimony;

d. Whether the testimony is requested in connection with a deposition or hearing;

e. A description of the books, papers, records or other real evidence requested;

f. The date, time and location for production or inspection and copying; and

g. In the case of a subpoena request for mental health records, confirmation that the conditions described in subrule 4.3(1) have been satisfied.

4.25(3) Each subpoena shall contain, as applicable, the following:

a. The caption of the case;

b. The name, address and telephone number of the person who requested the subpoena;

c. The name and address of the person to whom the subpoena is directed;

d. The date, time and location at which the person is commanded to appear;

e. Whether the testimony is commanded in connection with a deposition or hearing;

f. A description of the books, papers, records or other real evidence the person is commanded to produce;

g. The date, time and location for production or inspection and copying;

h. The time within which the motion to quash or modify the subpoena must be filed;

i. The signature, address and telephone number of the executive director or designee;

j. The date of issuance;

k. A return of service.

4.25(4) Unless a subpoena is requested to compel testimony or documents for rebuttal or impeachment purposes, the executive director or designee shall mail copies of all subpoenas to the parties to the contested case. The person who requested the subpoena is responsible for serving the subpoena upon the subject of the subpoena.

4.25(5) Any person who is aggrieved or adversely affected by compliance with the subpoena or any party to the contested case who desires to challenge the subpoena must, within 14 days after service of the subpoena, or before the time specified for compliance if such time is less than 14 days, file with the board a motion to quash or modify the subpoena. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

4.25(6) Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to issue a decision or the board may issue a decision. Oral argument may be scheduled at the discretion of the board or the administrative law judge. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

4.25(7) A person aggrieved by a ruling of an administrative law judge who desires to challenge that ruling must appeal the ruling to the board by serving on the executive director, either in person or by certified mail, a notice of appeal within ten days after service of the decision of the administrative law judge.

4.25(8) If the person contesting the subpoena is not the person under investigation, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board's decision is not final for purposes of judicial review until there is a final decision in the contested case.

655—4.26(17A) Motions.

4.26(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.

4.26(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.

4.26(3) The presiding officer may schedule oral argument on any motion.

4.26(4) Motions pertaining to the hearing must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the agency or an order of the presiding officer.

655—4.27(17A) Prehearing conference.

4.27(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the board office to all parties. For good cause the presiding officer may permit variances from this rule.

4.27(2) Each party shall bring to the prehearing conference:

a. A final list of witnesses the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names;

b. A final list of exhibits which the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them; and

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

4.27(3) In addition to the requirements of subrule 4.27(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters which the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters which will expedite the hearing.

4.27(4) Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference.

655—4.28(17A) Continuances. The executive director shall have the authority to grant a continuance after consultation, if needed, with the chairperson of the board.

A request for continuance of a contested case matter must be submitted in writing to the board not later than seven days prior to the scheduled date of the hearing. Exceptions shall be granted at the discretion of the executive director only in situations involving extenuating, extraordinary, or emergency circumstances.

655—4.29(17A) Hearing procedures.

4.29(1) The presiding officer presides at the hearing and may rule on motions, require briefs, issue a decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

4.29(2) All objections shall be timely made and stated on the record.

4.29(3) Parties have the right to participate or be represented in all hearings or prehearing conferences related to their case. Any party may be represented by an attorney or another person authorized by law.

4.36(3) *Time of filing.* The application shall be filed with the board office within 20 days after issuance of the final decision.

4.36(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

4.36(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the agency grants the application within 20 days after its filing.

655—4.37(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable.

655—4.38(17A) Emergency adjudicative proceedings.

4.38(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, the agency may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the agency by emergency adjudicative order. Before issuing an emergency adjudicative order the agency shall consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information;

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

4.38(2) *Issuance.*

a. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:

(1) Personal delivery;

(2) Certified mail, return receipt requested, to the last address on file with the agency;

(3) Certified mail to the last address on file with the agency;

(4) First-class mail to the last address on file with the agency; or

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

b. To the degree practicable, the agency shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

4.38(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the agency shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

4.38(4) *Completion of proceedings.* Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and Iowa Code sections 147.55, 152.10, 272C.4, 272C.5, 272C.6, and 272C.9.

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CHAPTER 6
NURSING PRACTICE FOR REGISTERED NURSES/LICENSED PRACTICAL NURSES

655—6.1(152) Definitions.

"Accountability" means being obligated to answer for one's acts, including the act of supervision.

"Advanced registered nurse practitioner (ARNP)" means a nurse with current licensure as a registered nurse in Iowa or who is licensed in another state and recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8, and is also registered in Iowa to practice in an advanced role. The ARNP is prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship. Advanced nursing practice occurs in a variety of settings, within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists.

"Basic nursing education" means a nursing program preparing a person for initial licensure to practice nursing as a registered nurse or licensed practical nurse.

"Board" as used in this chapter means the Iowa board of nursing.

"Certified clinical nurse specialist" means an ARNP prepared at the master's level who possesses evidence of current certification as a clinical specialist in an area of nursing practice by a national professional nursing association as approved by the board.

"Certified nurse-midwife" means an ARNP educated in the disciplines of nursing and midwifery who possesses evidence of current certification by a national professional nursing association approved by the board. The certified nurse-midwife is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically.

"Certified nurse practitioner" means an ARNP educated in the disciplines of nursing who has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care, and who possesses evidence of current certification by a national professional nursing association approved by the board.

"Certified registered nurse anesthetist" means an ARNP educated in the disciplines of nursing and anesthesia who possesses evidence of current certification by a national professional nursing association approved by the board.

"Competence in nursing" means having the knowledge and the ability to perform, skillfully and proficiently, the functions within the role of the licensed nurse.

"Minimum standards" means standards of practice that interpret the legal definition of nursing as well as provide criteria against which violations of the law can be determined.

"Nursing diagnosis" means a judgment made by a registered nurse, following a nursing assessment of individuals and groups about actual or potential responses to health problems, which forms the basis for determining effective nursing interventions.

"Nursing facility" means an institution as defined in Iowa Code chapter 135C. This definition does not include acute care settings.

"Nursing process" means ongoing assessment, nursing diagnosis, planning, intervention, and evaluation.

"Proximate area" means that the registered nurse analyzes the qualifications of the licensed practical nurse in relationship to nursing needs of the client in determining the appropriate distance within the building and the time necessary to be readily available to the licensed practical nurse.

"Unlicensed assistive personnel" is an individual who is trained to function in an assistive role to the registered nurse and licensed practical nurse in the provision of nursing care activities as delegated by the registered nurse or licensed practical nurse.

655—6.2(152) Minimum standards of nursing practice for registered nurses.

6.2(1) The registered nurse shall recognize and understand the legal implications within the scope of nursing practice. The scope of nursing practice considered to be minimum standards of nursing practice shall not be interpreted to include those practices currently ascribed to the advanced registered nurse practitioner.

6.2(2) The registered nurse shall utilize the nursing process in the practice of nursing, consistent with accepted and prevailing practice. The nursing process is ongoing and includes:

a. Nursing assessments about the health status of an individual or group.

b. Formulation of a nursing diagnosis based on analysis of the data from the nursing assessment.

c. Planning of nursing care which includes determining goals and priorities for actions which are based on the nursing diagnosis.

d. Nursing interventions implementing the plan of care.

e. Evaluation of the individual's or group's status in relation to established goals and the plan of care.

6.2(3) The registered nurse shall conduct nursing practice by respecting the rights of an individual or group.

6.2(4) The registered nurse shall conduct nursing practice by respecting the confidentiality of an individual or group, unless obligated to disclose under proper authorization or legal compulsion.

6.2(5) The registered nurse shall recognize and understand the legal implications of accountability. Accountability includes but need not be limited to the following:

a. Performing or supervising those activities and functions which require the knowledge and skill level currently ascribed to the registered nurse and seeking assistance when activities and functions are beyond the licensee's scope of preparation.

b. Assigning and supervising persons performing those activities and functions which do not require the knowledge and skill level currently ascribed to the registered nurse.

c. Using professional judgment in assigning and delegating activities and functions to unlicensed assistive personnel. Activities and functions which are beyond the scope of practice of the licensed practical nurse may not be delegated to unlicensed assistive personnel.

d. Supervising, among other things, includes any or all of the following:

(1) Direct observation of a function or activity.

(2) Assumption of overall responsibility for assessing, planning, implementing, and evaluating nursing care.

(3) Delegation of nursing tasks while retaining accountability.

(4) Determination that nursing care being provided is adequate and delivered appropriately.

e. Executing the regimen prescribed by a physician. In executing the medical regimen as prescribed by the physician, the registered nurse shall exercise professional judgment in accordance with minimum standards of nursing practice as defined in these rules. If the medical regimen prescribed by the physician is not carried out, based on the registered nurse's professional judgment, accountability shall include but need not be limited to the following:

(1) Timely notification of the physician who prescribed the medical regimen that the order(s) was not executed and reason(s) for same.

(2) Documentation on the medical record that the physician was notified and reason(s) for not executing the order(s).

f. Wearing identification which clearly identifies the nurse as a registered nurse when providing direct patient care unless wearing identification creates a safety or health risk for either the nurse or the patient.

655—6.3(152) Minimum standards of practice for licensed practical nurses.

6.3(1) The licensed practical nurse shall recognize and understand the legal implications within the scope of nursing practice. The licensed practical nurse shall perform services in the provision of supportive or restorative care under the supervision of a registered nurse or physician as defined in the Iowa Code.

6.3(2) The licensed practical nurse shall participate in the nursing process, consistent with accepted and prevailing practice, by assisting the registered nurse or physician. The licensed practical nurse may assist the registered nurse in monitoring, observing and reporting reactions to therapy.

6.3(3) The licensed practical nurse shall not perform any activity requiring the knowledge and skill ascribed to the registered nurse, including:

a. The initiation of or assessment related to procedures/therapies requiring the knowledge or skill level ascribed to the registered nurse.

b. The initiation of intravenous solutions, intravenous medications and blood components.

c. The administration of medicated intravenous solutions, intravenous medications and blood components.

d. The initiation or administration of medications requiring the knowledge or skill level currently ascribed to the registered nurse.

6.3(4) A licensed practical nurse, under the supervision of a registered nurse, may engage in the limited scope of practice of intravenous therapy. In providing the limited scope of therapy, the licensed practical nurse may add intravenous solutions without medications to established peripheral intravenous sites, regulate the rate of nonmedicated intravenous solutions, administer maintenance doses of analgesics via the patient-controlled analgesic pump set at a lock-out interval, and discontinue intravenous therapy. Nursing tasks which may be delegated in a certified end-stage renal dialysis unit by the registered nurse to the licensed practical nurse with documented training include:

a. Initiation and discontinuation of the hemodialysis treatment utilizing an established vascular access.

b. The administration of local anesthetic prior to cannulation of the peripheral vascular access site.

c. Administration of prescribed dosages of heparin solution or saline solution utilized in the initiation and discontinuation of hemodialysis.

6.3(5) The licensed practical nurse may provide nursing care in an acute care setting. When the nursing care provided by the licensed practical nurse in an acute care setting requires the knowledge and skill level currently ascribed to the registered nurse, a registered nurse or physician must be present in the proximate area. Acute care settings requiring the knowledge and skill ascribed to the registered nurse include, but are not limited to:

a. Units where care of the unstable, critically ill, or critically injured individual is provided.

b. General medical-surgical units.

c. Emergency departments.

d. Operating rooms. (A licensed practical nurse may assist with circulating duties when supervised by a registered nurse circulating in the same room.)

e. Postanesthesia recovery units.

f. Hemodialysis units.

g. Labor and delivery/birthing units.

h. Mental health units.

6.3(6) The licensed practical nurse may provide nursing care in a non-acute care setting. When the nursing care provided by the licensed practical nurse in a non-acute care setting requires the knowledge and skill level currently ascribed to the registered nurse, the registered nurse or physician must be present in the proximate area. The non-acute care settings requiring the knowledge and skill level ascribed to the registered nurse include, but are not limited to:

a. Community health. (Subrules 6.6(1) and 6.6(4) are exceptions to the "proximate area" requirement.)

b. School nursing. (Subrules 6.6(2) and 6.6(3) are exceptions to the "proximate area" requirement.)

c. Occupational nursing.

d. Correctional facilities.

e. Community mental health nursing.

6.3(7) The licensed practical nurse shall conduct nursing practice by respecting the rights of an individual or group.

6.3(8) The licensed practical nurse shall conduct nursing practice by respecting the confidentiality of an individual or group, unless obligated to disclose under proper authorization or legal compulsion.

6.3(9) The licensed practical nurse shall recognize and understand the legal implications of accountability. Accountability includes but need not be limited to the following:

a. Performing those activities and functions which require the knowledge and skill level currently ascribed to the licensed practical nurse and seeking assistance when activities and functions are beyond the licensee's scope of preparation.

b. Accepting responsibility for performing assigned and delegated functions and informing the registered nurse when assigned and delegated functions are not executed.

c. Executing the medical regimen prescribed by a physician. In executing the medical regimen as prescribed by the physician, the licensed practical nurse shall exercise prudent judgment in accordance with minimum standards of nursing practice as defined in these rules. If the medical regimen prescribed by the physician is not carried out based on the licensed practical nurse's prudent judgment, accountability shall include but need not be limited to the following:

(1) Timely notification of the physician who prescribed the medical regimen that said order(s) was not executed and reason(s) for same.

(2) Documentation on the medical record that the physician was notified and reason(s) for not executing the order(s).

d. Wearing identification which clearly identifies the nurse as a licensed practical nurse when providing direct patient care unless wearing identification creates a safety or health risk for either the nurse or the patient.

655—6.4(152) Additional acts which may be performed by registered nurses.

6.4(1) A registered nurse shall be permitted to practice as a diagnostic radiographer while under the supervision of a licensed practitioner provided that appropriate training standards for use of radiation-emitting equipment are met as outlined in 641—42.1(136C).

6.4(2) A registered nurse, licensed pursuant to Iowa Code chapter 152, may staff an authorized ambulance, rescue, or first response service provided the registered nurse can document equivalency through education and additional skills training essential in the delivery of out-of-hospital emergency care. The equivalency shall be accepted when documentation has been reviewed and approved at the local level by the medical director of the ambulance, rescue, or first response service in accordance with the form adopted by the Iowa department of public health bureau of emergency medical services. An exception to this subrule is the registered nurse who accompanies and is responsible for a transfer patient.

This rule is intended to implement Iowa Code section 147A.12 and chapters 136C and 152.

655—6.5(152) Additional acts which may be performed by licensed practical nurses.

6.5(1) A licensed practical nurse shall be permitted to supervise unlicensed assistive personnel under the provisions of Iowa Code section 152.1(4)*"b."*

a. Supervision, among other things, includes any or all of the following:

(1) Direct observation of a function or activity.

(2) Delegation of nursing tasks while retaining accountability.

(3) Determination that nursing care being provided is adequate and delivered appropriately.

b. Supervision shall be in accordance with the following:

(1) A licensed practical nurse working under the supervision of a registered nurse shall be permitted to supervise in an intermediate care facility for the mentally retarded or in a residential health care setting.

(2) A licensed practical nurse working under the supervision of a registered nurse shall be permitted to supervise in a nursing facility.

The licensed practical nurse shall be required to complete a curriculum which has been approved by the board and designed specifically for the supervision role of the licensed practical nurse in a nursing facility. The course must be presented by a board-approved nursing program or an approved provider of continuing education. Documentation of the completion of the curriculum as outlined in this subparagraph shall be maintained by the licensed practical nurse.

(3) A licensed practical nurse shall be entitled to supervise without the educational requirement outlined in subparagraph 6.5(1)*"b"*(2) if the licensed practical nurse was performing in a supervisory role on or before October 6, 1982. The licensed practical nurse being employed in a supervisory role after the enactment of these rules shall complete the curriculum outlined in subparagraph 6.5(1)*"b"*(2) within six months of employment.

(4) A licensed practical nurse working under the supervision of a registered nurse may direct the activities of other licensed practical nurses and unlicensed assistive personnel in an acute care setting in giving care to individuals assigned to the licensed practical nurse. The registered nurse must be in the proximate area.

6.5(2) A licensed practical nurse shall be permitted to practice as a diagnostic radiographer while under the supervision of a licensed practitioner provided that appropriate training standards for use of radiation-emitting equipment are met as outlined in 641—42.1(136C).

6.5(3) A licensed practical nurse who has completed a board-approved intravenous therapy certification course offered by a board-approved provider of continuing education shall be permitted to perform, in addition to the functions set forth in subrule 6.3(4), procedures related to the expanded scope of administration of intravenous therapy in a licensed hospital, licensed skilled nursing facility and a certified end-stage renal dialysis unit. The board-approved course shall incorporate the responsibilities of the nurse when providing intravenous therapy to children, adults and elderly adults. When providing intravenous therapy, the licensed practical nurse shall be under the supervision of the registered nurse. Procedures which may be assumed if delegated by the registered nurse are as follows:

a. Initiation of a peripheral intravenous line for continuous or intermittent therapy using an intermittent infusion device or a therapy cannula not to exceed three inches in length.

b. Administration via peripheral lines, after the first dose has been administered by the registered nurse, of premixed electrolyte solutions or premixed vitamin solutions. The solutions must be prepackaged by the manufacturer or premixed and labeled by a registered pharmacist or registered nurse.

c. Administration via peripheral lines, after the first dose has been administered by the registered nurse, of solutions containing potassium chloride that do not exceed 40 meq per liter and at a rate that does not exceed 10 meq per hour. The solutions must be prepackaged by the manufacturer or premixed and labeled by a registered pharmacist or registered nurse.

d. Administration via peripheral lines, after the first dose has been administered by the registered nurse, of intravenous antibiotic solutions prepackaged by the manufacturer or premixed and labeled by a registered pharmacist or registered nurse.

e. Maintenance of the patency of peripheral intravenous lines with heparin irrigation solution or normal saline irrigation solution.

6.5(4) Acts which may not be delegated by the registered nurse to the licensed practical nurse are as follows:

a. Administration of medication by bolus or IV push except maintenance doses of analgesics via a patient-controlled analgesia pump set at a lock-out interval.

b. Administration of blood and blood products; vasodilators, vasopressors, oxytoxics, chemotherapy, colloid therapy, total parenteral nutrition, anticoagulants, antiarrhythmics, thrombolytics and solutions with a total osmolarity of 600 or greater.

c. Provision of intravenous therapy to a client under the age of 12 or any client weighing less than 80 pounds, with the exception of those activities authorized in the limited scope of practice found in subrule 6.3(4).

d. Provision of intravenous therapy in any setting except licensed hospitals, licensed skilled nursing facilities and certified end-stage renal dialysis units with the exception of those activities authorized in the limited scope of practice found in subrule 6.3(4).

6.5(5) To be eligible for intravenous therapy certification, the licensee shall hold a current unrestricted Iowa license and documentation of 2080 hours of practice as a licensed practical nurse and shall hold a current unrestricted Iowa license or an unrestricted license in another state recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8.

This rule is intended to implement Iowa Code chapters 136C and 152, and 2000 Iowa Acts, House File 2105.

655—6.6(152) Specific nursing practice for licensed practical nurses.

6.6(1) The licensed practical nurse shall be permitted to provide supportive and restorative care in the home setting under the supervision of a registered nurse, as defined in subrule 6.2(5), or a physician. When the licensed practical nurse provides care under the supervision of the registered nurse, the initial assessment and ongoing application of the nursing process shall be provided by the registered nurse.

6.6(2) The licensed practical nurse shall be permitted to provide supportive and restorative care to a specific student in the school setting in accordance with the student's health plan when under the supervision of and as delegated by the registered nurse employed by the school district.

6.6(3) The licensed practical nurse shall be permitted to provide supportive and restorative care in a Head Start program under the supervision of a registered nurse, as defined in subrule 6.2(5), or a physician if the licensed practical nurse were in this position prior to July 1, 1985.

6.6(4) The licensed practical nurse shall be permitted to provide supportive and restorative care in a camp setting under the supervision of a registered nurse, as defined in subrule 6.2(5), or a physician. When the licensed practical nurse provides care under the supervision of the registered nurse, the initial assessment and ongoing application of the nursing process are performed by the registered nurse. The licensed practical nurse is responsible for requesting registered nurse consultation as needed.

This rule is intended to implement Iowa Code sections 17A.3 and 152.1.

655—6.7(152) Specific nursing practice for registered nurses. A registered nurse, while circulating in the operating room, shall provide supervision only to persons in the same operating room.

This rule is intended to implement Iowa Code section 152.1.

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CHAPTER 7
ADVANCED REGISTERED NURSE PRACTITIONERS
[Prior to 8/26/87, Nursing Board[590] Ch 7]

655—7.1(152) Definitions.

"Advanced registered nurse practitioner (ARNP)" means a nurse with current licensure as a registered nurse in Iowa or who is licensed in another state and recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8, and is also registered in Iowa to practice in an advanced role. The ARNP is prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship. Advanced nursing practice occurs in a variety of settings, within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists.

"Basic nursing education" as used in this chapter is a nursing program that prepares a person for initial licensure to practice nursing as a registered nurse.

"Board" as used in this chapter means Iowa board of nursing.

"Certified clinical nurse specialist" is an ARNP prepared at the master's level who possesses evidence of current advanced level certification as a clinical specialist in an area of nursing practice by a national professional nursing certifying body as approved by the board.

"Certified nurse-midwife" is an ARNP educated in the disciplines of nursing and midwifery who possesses evidence of current advanced level certification by a national professional nursing certifying body approved by the board. The certified nurse-midwife is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically.

"Certified nurse practitioner" is an ARNP educated in the disciplines of nursing who has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care, and who possesses evidence of current certification by a national professional nursing certifying body approved by the board.

"Certified registered nurse anesthetist" is an ARNP educated in the disciplines of nursing and anesthesia who possesses evidence of current advanced level certification or recertification, as applicable, by a national professional nursing certifying body approved by the board.

"Collaboration" is the process whereby an ARNP and physician jointly manage the care of a client.

"Collaborative practice agreement" means an ARNP and physician practicing together within the framework of their respective professional scopes of practice. This collaborative agreement reflects both independent and cooperative decision making and is based on the preparation and ability of each practitioner.

"Consultation" is the process whereby an ARNP seeks the advice or opinion of a physician, pharmacist, or another member of the health care team. ARNPs practicing in a noninstitutional setting as sole practitioners, or in small clinical practice groups, shall regularly consult with a licensed physician or pharmacist regarding the distribution, storage, and appropriate use of controlled substances.

"Controlled substance" is a drug, substance, or immediate precursor in Schedules I through V of division II, Iowa Code chapter 124.

"National professional nursing certifying body" is a professional nursing certifying body approved by the board. Agencies approved by the board include the American Nurses Credentialing Center, the American Academy of Nurse Practitioners, the American College of Nurse-Midwives Certification Council, the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, the National Certification Board of Pediatric Nurse Practitioners and Nurses, the National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties, the Oncology Nursing Certification Organization, and the American Association of Critical Care Nurses Certification Corporation.

"Physician" means a medical doctor licensed under Iowa Code chapter 148 or osteopathic physician and surgeon licensed under Iowa Code chapter 150A.

"Prescriptive authority" is the authority granted to an ARNP registered in Iowa in a recognized nursing specialty to prescribe, deliver, distribute, or dispense prescription drugs, devices, and medical gases when the nurse is engaged in the practice of that nursing specialty. Registration as a practitioner with the Federal Drug Enforcement Administration and the Iowa board of pharmacy examiners extends this authority to controlled substances. ARNPs shall obtain a copy of the Iowa Pharmacy Law and Informational Manual. ARNPs are encouraged to subscribe to the Iowa Board of Pharmacy Newsletter.

"Referral" is the process whereby the ARNP directs the client to a physician or another health care professional for management of a particular problem or aspect of the client's care.

655—7.2(152) General requirements for the advanced registered nurse practitioner.

7.2(1) *Specialty areas of nursing practice for the advanced registered nurse practitioner.* The board derives its authority to define the educational and clinical experience that is necessary to practice at an advanced registered nurse practitioner level under the provisions of Iowa Code section 152.1(6)*"d."* The specialty areas of nursing practice for the advanced registered nurse practitioner which shall be considered as legally authorized by the board are as follows:

a. Certified clinical nurse specialist.

b. Certified nurse-midwife.

c. Certified nurse practitioner.

d. Certified registered nurse anesthetist.

7.2(2) *Titles and abbreviations.* A registered nurse who has completed all requirements to practice as an advanced registered nurse practitioner and who is registered with the board to practice shall use the title advanced registered nurse practitioner (ARNP). Utilization of the title which denotes the specialty area is at the discretion of the advanced registered nurse practitioner.

a. No person shall practice or advertise as or use the title of advanced registered nurse practitioner for any of the defined specialty areas unless the name, title and specialty area appear on the official record of the board and on the current license.

b. No person shall use the abbreviation ARNP for any of the defined specialty areas or any other words, letters, signs or figures to indicate that the person is an advanced registered nurse practitioner unless the name, title and specialty area appears on the official record of the board and on the current license.

c. Any person found to be practicing under the title of advanced registered nurse practitioner or using the abbreviation ARNP without being registered as defined in this subrule shall be subject to disciplinary action.

7.2(3) *General education and clinical requirements.*

a. The general educational and clinical requirements necessary for recognition by the board as a specialty area of nursing practice are as follows:

(1) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills as approved by the board; or

(2) Satisfactory completion of a formal advanced practice educational program of study in a nursing specialty area approved by the board and appropriate clinical experience as approved by the board.

b. Additional requirements. Nothing in this rule shall be construed to mean that additional general educational or clinical requirements cannot be defined in a specialty area.

7.2(4) *Application process.* A registered nurse who wishes to practice as an advanced registered nurse practitioner shall submit the following to the office of the board:

a. An advanced registered nurse practitioner application form which may be obtained from the office of the board.

b. A registration fee as established by the board.

c. A copy of the time-dated, advanced level certification by appropriate national certifying body evidencing that the applicant holds current certification in good standing; copy of official transcript directly from the formal advanced practice educational program maintaining the records necessary to document that all requirements have been met in one of the specialty areas of nursing practice as listed in subrule 7.2(1). The transcript shall verify the date of completion of the program/graduation and the degree conferred. A registered nurse may make application to practice in more than one specialty area of nursing practice.

7.2(5) *Initial registration.* The executive director or a designee shall have the authority to determine if all requirements have been met for registration as an advanced registered nurse practitioner. If it has been determined that all requirements have been met:

a. Official licensure records of the registered nurse shall denote registration as an advanced registered nurse practitioner as well as the specialty area(s) of nursing practice.

b. The registered nurse shall be issued a registration card and a certificate to practice as an ARNP which clearly denotes the name, title, specialty area(s) of nursing practice, and expiration date of registration. The expiration date shall be based on the same period of licensure to practice as a registered nurse.

7.2(6) *Registration completion.* The registered nurse shall complete the registration process within 12 months of receipt of the application materials. The board reserves the right to destroy the documents after 12 months.

7.2(7) *Denial of registration.* If it has been determined that all requirements have not been met, the registered nurse shall be notified in writing of the reason(s) for the decision. The applicant shall have the right of appeal to the Iowa board of nursing within 30 days of denial by the executive director or designee.

7.2(8) *Application process for renewal of registration.* Renewal of registration for the advanced registered nurse practitioner shall be for the same period of licensure to practice as a registered nurse. The executive director or a designee shall have the authority to determine if all requirements have been met for renewal as an advanced registered nurse practitioner. A registered nurse who wishes to continue practice as an advanced registered nurse practitioner shall submit the following at least 30 days prior to the license expiration to the office of the Iowa board of nursing:

a. Completed renewal application form.

b. Renewal fee as outlined in rule 655—3.1(17A,147,152,272C), definition of "fees."

c. Copy of current time-dated, advanced level certification by appropriate national certifying body.

7.2(9) *Continuing education requirements.* Continuing education shall be met as required for certification by the relevant national certifying body, as outlined in 655—subrule 5.2(3), paragraph *"e."*

7.2(10) *Denial of renewal registration.* If it has been determined that all requirements have not been met, the applicant shall be notified in writing of the reason(s) for the decision. Failure to obtain the renewal will result in termination of registration and of the right to practice in the advanced registered nurse practitioner specialty area(s). The applicant shall have the right of appeal to the Iowa board of nursing within 30 days of denial of the executive director or designee.

7.2(11) *Registration to practice as an advanced registered nurse practitioner restricted, revoked, or suspended.* Rescinded IAB 12/29/99, effective 2/2/00.

These rules are intended to implement Iowa Code sections 17A.3, 147.10, 147.53, 147.76, 147.107(6) and 152.1 and 2000 Iowa Acts, House File 2105.

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CHAPTER 16
NURSE LICENSURE COMPACT

655—16.1(152E) Definitions.

"Board" means a party state's regulatory body responsible for issuing nurse licenses.

"Information system" means the coordinated licensure information system.

"Primary state of residence" means the state of a person's declared fixed permanent and principal home for legal purposes; domicile.

"Public" means any individual or entity other than designated staff or representatives of party state boards or the National Council of State Boards of Nursing, Inc.

655—16.2(152E) Issuance of a license by a compact party state.

16.2(1) A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. Such evidence shall include a declaration signed by the licensee. Further evidence that may be requested may include, but is not limited to:

a. A driver's license with a home address;

b. Voter registration card displaying a home address; or

c. Federal income tax return declaring the primary state of residence.

16.2(2) A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed 30 days.

16.2(3) The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the 30-day period set out in 16.2(2) of this rule shall be stayed until resolution of the pending investigation.

16.2(4) The former home state license shall no longer be valid upon the issuance of a new home state license.

16.2(5) If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten business days, and the former home state may take action in accordance with that state's laws and rules.

655—16.3(152E) Limitations on multistate licensure privilege. All home state board disciplinary orders, agreed or otherwise, which limit the scope of the licensee's practice or require monitoring of the licensee as a condition of the order shall include the requirement that the licensee will limit the licensee's practice to the home state during the pendency of the order. This requirement may allow the licensee to practice in other party states with prior written authorization from both the home state and party state boards.

655—16.4(152E) Information system.

16.4(1) Levels of access.

a. The public shall have access to nurse licensure information limited to:

(1) The nurse's name.

(2) Jurisdiction(s) of licensure.

(3) License expiration date(s).

(4) Licensure classification(s) and status(es).

(5) Public emergency and final disciplinary actions, as defined by contributing state authority.

(6) The status of multistate licensure privileges.

b. Nonparty state boards shall have access to all information system data except current significant investigative information and other information as limited by contributing party state authority.

c. Party state boards shall have access to all information system data contributed by the party states and other information as limited by contributing nonparty state authority.

16.4(2) The licensee may request in writing to the home state board review of the data relating to the licensee in the information system. In the event a licensee asserts that any data relating to the licensee is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The board shall verify and within ten business days correct inaccurate data in the information system.

16.4(3) The board shall report to the information system within ten business days, a disciplinary action, agreement or order which requires participation in alternative programs or which limits practice or requires monitoring (except agreements and orders relating to participation in alternative programs required to remain nonpublic by contributing state authority), dismissal of complaint, and changes in status of disciplinary action, or licensure encumbrance.

16.4(4) Current significant investigative information shall be deleted from the information system within ten business days upon report of disciplinary action, agreement or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint.

16.4(5) Changes to licensure information in the information system shall be completed within ten business days upon notification by the board.

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REVENUE AND FINANCE DEPARTMENT[701]

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701—2.76(421,17A) No factual dispute contested case. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs, and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

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CHAPTER 3
VOLUNTARY DISCLOSURE PROGRAM

701—3.1(421,422,423) Scope of the voluntary disclosure program. Any person located outside of Iowa who is subject to Iowa tax or tax collection responsibilities may be eligible for the voluntary disclosure program. Being subject to Iowa tax may occur when a person has Iowa source income or has representatives or other presence in Iowa. Certain activities by such persons may create Iowa tax return filing requirements for Iowa source income, as defined in 701—subrule 3.1(1), not previously reported. In addition, activities may also result in tax liabilities that are past due and owing.

The purpose of the voluntary disclosure program is to encourage unregistered business entities and persons to voluntarily contact the department regarding unreported Iowa source income. The person or the person's representative may initially contact the department on an anonymous basis. Anonymity of the taxpayer can be maintained until the voluntary disclosure agreement is executed by the taxpayer and the department.

The voluntary disclosure program may be used by the department and the taxpayer to report previous periods of Iowa source income and to settle outstanding tax, penalty and interest liabilities, but it must also ensure future tax compliance by the taxpayer.

3.1(1) *Type of taxes eligible.* Only taxes, penalties and interest related to Iowa source income are eligible for settlement under the voluntary disclosure program. For purposes of this rule, "Iowa source income" means the tax base and the tax collection responsibility for the following enumerated taxes: corporate income tax, franchise tax, fiduciary income tax, withholding income tax, individual income tax, local option school district income surtax, state sales tax, state use tax, motor fuel taxes, cigarette and tobacco taxes, and local option taxes.

3.1(2) *Eligibility of the taxpayer.* The department has discretion to determine who is eligible for participation in the voluntary disclosure program. In making the determination, the department may consider the following factors:

a. The location of the person must be outside of Iowa;

b. The person must be subject to Iowa tax on Iowa source income or have Iowa tax collection responsibilities;

c. The person must not currently be under audit or examination by the department or under criminal investigation by the department;

d. The person must not have had any prior contact with the department or a representative of the department which could lead to audit or assessment associated with the tax types or tax periods sought to be addressed under the program;

e. The type and extent of activities resulting in Iowa source income;

f. Failure to report the Iowa source income or pay any liability was not due to fraud, intentional misrepresentation, an intent to evade tax, or willful disregard of Iowa tax laws; and

g. Any other factors which are relevant to the particular situation.

3.1(3) *Application to participate in the voluntary disclosure program.* To apply for the voluntary disclosure program, the person or the person's representative must submit a written application to the Nonfiler Unit, Compliance Division, Iowa Department of Revenue and Finance, P.O. Box 10456, Des Moines, Iowa 50306-0456. To be valid, an application must include the following:

a. The types of taxes involved;

b. Separate statements evidencing compliance with each of the eligibility requirements set forth in 701—subrule 3.1(2);

c. A complete and accurate description of the person's activities resulting in Iowa source income, the source of the Iowa source income or Iowa tax collection responsibilities, the type and dates, if available, of the activities in Iowa, a description of the product or service sold in Iowa, and the number of activity occurrences in Iowa per year or whether the activities in Iowa per year were continuous;

d. The reason for noncompliance with Iowa tax law;

e. An estimation of the amount of unpaid Iowa tax by the tax type and applicable tax period(s); and

f. Any other matters which are relevant to the particular situation.

The department reserves the right to request additional information that the department determines is necessary to determine or approximate the liability due, and to determine the applicant's eligibility, the accuracy of information presented and statements asserted by the applicant, and the terms of the voluntary disclosure agreement.

3.1(4) *Acceptance or rejection of an application for the voluntary disclosure program.* The department has the discretion to determine if an applicant meets all of the requirements for the voluntary disclosure program. The department will notify an applicant in writing regarding whether the applicant's application for participation in the program is accepted or rejected.

Rejection of an application prior to the execution of an agreement may be based on the applicant's ineligibility; the applicant's noncompliance in submitting information, documents, evidence, or returns within the time period as requested by the department; misrepresentation of a material fact by the applicant or the applicant's representative; or the department's determination that the matter may be best handled by using other means of administration.

3.1(5) *Terms of the voluntary disclosure agreement.* The department has the discretion to settle all outstanding Iowa source income tax, penalty and interest liabilities of the eligible applicant. Settlement terms are on a case-by-case basis. The existence of the voluntary disclosure agreement and the terms of the agreement are to be held confidential by all parties to the agreement. Items considered by the department in determining the settlement terms include: the type of tax; the tax periods at issue; the reason for noncompliance; whether the tax is a trust fund tax; the types of activities resulting in the Iowa source income; the frequency of the activities that resulted in the Iowa source income; and any other matters which are relevant to the particular situation.

If a taxpayer initiates the contact with the department and is eligible for the voluntary disclosure program and complies with the agreement terms, the maximum prior years for which the department will generally audit and pursue settlement and collection will be five years, absent an intent to defraud, the making of material misrepresentations of fact, or an intent to evade tax.

All voluntary disclosure agreements must require that the applicant file future Iowa tax returns, unless the activity by the applicant resulting in the Iowa source income has changed or there has been a change in the law, rules, or court cases which dictate a different result.

The department reserves the right to audit all returns, spreadsheets or other documents submitted by the applicant or a third party to verify the facts and whether the terms of the voluntary disclosure agreement have been met. The department may audit information submitted by the applicant at any time within the allowed statutory limitation period. The department may also assess any tax, penalty, and interest found to be due in addition to the amount of original tax reported. The statute of limitations for assessment and statute of limitations for refunds begin to run as provided by law.

3.1(6) *Commencement of the voluntary disclosure agreement.* The voluntary agreement commences on the date of the execution of the voluntary disclosure agreement. Execution of the agreement is complete when the agreement is executed by the taxpayer and the department's authorized personnel. Prior to the execution of the voluntary disclosure agreement by the taxpayer and the department, the taxpayer is not protected from the department's regular audit process if the identity of the taxpayer, as an applicant, is unknown to the department. However, if the department has knowledge of the taxpayer's identity, as an applicant, the department will not take audit action against the taxpayer during the voluntary disclosure process. However, if a voluntary disclosure agreement is not reached, the department may assess tax, penalty and interest as provided by law at the time the identity of the applicant becomes known to the department.

3.1(7) *Voiding a voluntary disclosure agreement.* The department also has the authority to declare a voluntary disclosure agreement null and void subsequent to the execution of the agreement. The department may void the contractual agreement if the department determines that a misrepresentation of a material fact was made by the person or a third party representing the person to the department. The department may also void a voluntary disclosure agreement if the department determines any of the following has occurred:

a. The person does not submit information requested by the department within the time period specified by the department, including any extensions granted by the department;

b. The person fails to file future Iowa returns as agreed to in the voluntary disclosure agreement;

c. The person does not pay the agreed settlement liability within the time period designated by the department, including any extensions of time that may be granted by the department;

d. The person does not remit all taxes imposed upon or collected by the person for all subsequent tax periods and all tax types that are subject to the voluntary disclosure agreement;

e. The person fails to prospectively comply with Iowa tax law. Whether the person has failed to prospectively comply with Iowa tax law is determined by the department on a case-by-case basis;

f. The person, based on a determination by the department, materially understates the person's tax liability; or

g. The person has made a material breach of the terms of the voluntary disclosure agreement.

Voiding of the agreement results in nonenforceability of the agreement by the applicant and allows the department to proceed to assess tax, penalty and interest for that person's Iowa source income or tax collection responsibilities for all periods within the statute of limitations. The department reserves the right to audit all returns, spreadsheets or other documents submitted by the applicant or a third party and to make an assessment for all tax, penalty and interest owed, if the applicant is justifiably rejected for the voluntary disclosure program or the agreement between the person and the department is declared by the department to be null and void.

If the voluntary disclosure agreement is voided or the application for the program is rejected and the department issues an assessment, the taxpayer may protest the assessment pursuant to 701—Chapter 7 and raise the issue of the propriety of voiding the voluntary disclosure agreement or rejecting the application. If the department does not issue an assessment, but does reject the application or voids the agreement, such action is not subject to appeal under 701—Chapter 7, but is considered to be "other agency action" as set forth in Iowa Code section 17A.19(3). See *Purethane Inc. v. Iowa State Board of Tax Review*, 498 N.W.2d 706 (Iowa 1993).

3.1(8) *Partnerships, partners, "S" corporations, shareholders in "S" corporations, trusts, and trust beneficiaries.* Once the department has initiated an audit or investigation of any type of partnership, partners of the partnership, "S" corporations, a shareholder in an "S" corporation, a trust, or trust beneficiaries, the department is deemed to have initiated an audit or investigation of the entity and of all those who receive Iowa source income from or have an interest in such an entity for purposes of eligibility under subrule 3.1(2) for participation in the voluntary disclosure program.

3.1(9) *Transfer or assignment.* The terms of the voluntary disclosure agreement are valid and enforceable by and against all parties, including their transferees and assignees.

3.1(10) *Confidentiality.* The terms of each voluntary disclosure contract are determined on a case-by-case basis. Except as may be specifically required by law or preexisting written agreement, the existence of a voluntary disclosure agreement and the terms of the voluntary disclosure agreement are to be held confidential by the parties to the voluntary disclosure agreement, their representatives, transferees, and assignees. Disclosure of the existence of a voluntary disclosure agreement or the terms of such an agreement in a manner contrary to this rule may result in the agreement being declared null and void at the discretion of the nondisclosing party.

These rules are intended to implement Iowa Code section 421.17.

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CHAPTER 4
MULTILEVEL MARKETER AGREEMENTS

701—4.1(421) Multilevel marketers—in general. Multilevel marketer companies may enter into a written contract with the department to collect and remit state and local option sales taxes on sales of tangible personal property to independent distributors for resale and remit the taxes directly to the department. To be eligible for the multilevel marketer's program, the company must meet certain eligibility requirements and agree to certain terms in the multilevel marketer agreement as set forth in 701—subrules 4.1(3) and 4.1(4). All written contacts with the department should be sent to Nonfiler Unit, Compliance Division, Iowa Department of Revenue and Finance, P.O. Box 10456, Des Moines, Iowa 50306-0456.

4.1(1) *Definitions.* The following definitions of terms are applicable to this chapter:

"Independent distributor" means a seller who purchases products for resale to an Iowa consumer based on a price suggested by a multilevel marketer.

"Multilevel marketer" means a wholesaler that sells tangible personal property for resale via a network of independent distributors who then sell the property to the ultimate consumers located in Iowa at a retail price suggested by the multilevel marketer.

"Sales tax" or *"sales taxes"* for the purpose of this rule means Iowa state sales tax, including local option sales and service taxes, and state use tax. To determine if local option sales and service taxes are due, see 701—107.2(422B), 701—107.3(422B), and 701—108.3(422E).

4.1(2) *Collection of tax.* Iowa state sales tax is to be collected on the wholesale or retail selling price if delivery of the multilevel marketer's tangible personal property occurs in Iowa or the property is used in Iowa (see subparagraph 4.1(4)*"a"*(1) for further details). In addition, local option sales tax is due on the sale if delivery of the tangible personal property to the consumer occurs within a local option tax jurisdiction. See information and examples illustrating delivery and taxation in 701—107.2(422B), 701—107.3(422B), and 701—108.3(422E).

4.1(3) *Eligibility requirements.* To be eligible for a multilevel marketer agreement as a multilevel marketer, the following criteria must be met:

a. Tangible personal property is sold by the multilevel marketer to an independent distributor for resale to an Iowa end user or for a distributor's personal use.

b. Unless authorized by the department, the multilevel marketer must not have been previously required to be registered to remit sales tax.

c. The multilevel marketer must have contacted the department with a request to collect and remit sales taxes directly to the department on sales made by an independent distributor.

d. The multilevel marketer must not be under audit or examination by the department on the effective date of the agreement.

The department has full discretion to determine if a multilevel marketer meets the eligibility requirements for a multilevel marketer agreement. The department can request any and all information and documentation necessary to determine whether eligibility requirements are met. Failure to timely submit information and documents requested by the department will result in the department's refusal to enter into an agreement with the multilevel marketer.

4.1(4) *Terms of the multilevel marketer agreement.* The multilevel marketer agreement will become effective on the date an authorized representative of the multilevel marketer executes the agreement. Unless terminated in accordance with subrule 4.1(5), the multilevel marketer agreement remains in effect as long as the multilevel marketer has an independent distributor making sales in Iowa. Terms of agreements are based on results of negotiations between the multilevel marketer and the department. However, the following general terms must be in each multilevel marketer agreement:

a. The multilevel marketer agrees to the following terms:

(1) The multilevel marketer agrees to collect tax on the following three types of sales, excluding sales properly exempt from tax and evidenced by a valid exemption certificate:

1. The multilevel marketer agrees to collect sales tax from the independent distributors based on the suggested retail price of its product;

2. If the multilevel marketer allows independent distributors to purchase its product at a wholesale price for the distributor's personal use, then the multilevel marketer agrees to collect sales tax on sales which are based on the wholesale price to the independent Iowa distributor, unless the department waives this requirement; and

3. The multilevel marketer agrees to collect sales tax on all retail sales by the multilevel marketer to consumers that are subject to sales tax;

(2) The multilevel marketer will timely remit sales tax on transactions described in subparagraph 4.1(4)*"a"*(1);

(3) The multilevel marketer will maintain records to establish the accuracy of the sales tax returns within the applicable statutes of limitation;

(4) The multilevel marketer agrees that the sales tax shall be added to the retail price charged to the consumer, as required by Iowa Code section 422.48;

(5) The multilevel marketer agrees to be subject to audit and to pay any tax, penalty, and interest that are ultimately found to be legally due and that were required to be collected by the multilevel marketer under Iowa law, these rules and the multilevel marketer agreement;

(6) The multilevel marketer agrees to abide by the rules in 701—Chapter 4; and

(7) The multilevel marketer agrees to register for an Iowa retailer's use tax permit.

b. The department agrees to the following terms:

(1) The department will not audit, assess or demand payment of sales tax, penalty or interest from the multilevel marketer for any tax periods ending before the effective date of the multilevel marketer agreement.

(2) Unless required for transactions outside the multilevel marketer agreement, the department will not require the multilevel marketer to retroactively register for an Iowa sales tax permit or file Iowa sales tax returns for periods ending on or before the effective date of this agreement.

(3) The department agrees to allow a deduction from taxable sales reported by the multilevel marketer for merchandise returned by an independent distributor for which tax has already been paid to the department and for which the multilevel marketer, via the distributor, has allowed a credit or refund of the tax to the consumer.

c. Other general agreement terms:

(1) The multilevel marketer agreement is binding upon all parties, including their successors and assignees; and

(2) The terms, provisions, interpretations and enforcement of the multilevel marketer agreement are to be governed by the laws of the state of Iowa.

d. Refunds. Refunds for any overpayment of taxes paid by a consumer as a result of a multilevel marketer agreement should be claimed on the proper Iowa refund claim form as designated by the director.

Under this agreement, if the retail sale is made by an Iowa retailer to an out-of-state consumer, the multilevel marketer agrees to forego any claim for refund of tax which was paid on such sale.

4.1(5) *Termination of a multilevel marketer agreement.* If any of the following events occur, an executed multilevel marketer agreement may be declared null and void:

a. Termination of a multilevel marketer agreement at the department's discretion.

(1) The multilevel marketer has misrepresented any material fact regarding its activities, operations, tax liabilities, or eligibility under the agreement.

(2) It is determined by the department that the multilevel marketer had been notified that it was to be or was under audit by the department prior to the time the multilevel marketer executed the multilevel marketer agreement.

b. Termination of a multilevel marketer agreement by mutual agreement of the parties.

(1) Change occurs in law that impacts the tax liability subject to the multilevel marketer agreement.

(2) Collection and remittance of sales tax as required under the agreement are more feasible by other means.

Written notice of termination will be promptly given by the department in the event of termination under paragraph 4.1(5)*"a."*

4.1(6) *Liability of independent distributors.* After execution of a multilevel marketer agreement, an independent distributor must collect, report, and remit to the department, unless remitted to the multilevel marketer, any and all sales taxes that the independent distributor is required to collect, report, and remit that exceed the amount of tax that the independent distributor has previously remitted to the multilevel marketer company. If such excess tax is remitted to the multilevel marketer, the multilevel marketer shall report and remit the tax to the department.

EXAMPLE 1. An independent distributor purchased products from the multilevel marketer at the wholesale price because the distributor thought that the product would be for the personal use of the distributor. The distributor paid Iowa tax based on the wholesale price to the multilevel marketer and the multilevel marketer remitted the tax to the state of Iowa. Subsequently, the distributor resold the product to an Iowa customer at a retail price, which is greater than the wholesale price. The distributor is required to charge Iowa tax on the retail price. The distributor is also required to report and remit directly to the department or the multilevel marketer the difference between the tax previously paid on the wholesale price and the tax collected on the retail price from the Iowa customer.

EXAMPLE 2. An independent distributor purchased products from a multilevel marketer for resale at the retail price suggested by the multilevel marketer. Tax was collected by the multilevel marketer from the independent distributor on the suggested retail price of the products and remitted to the department by the multilevel marketer. The independent distributor subsequently sold the product to an Iowa customer for a price greater than the suggested retail price. The independent distributor is required to charge Iowa tax on the full sale price. The independent distributor is also required to report and remit directly to the department or to the multilevel marketer the difference between the tax previously paid on the suggested retail price and the tax collected on the price charged the Iowa customer.

If an independent distributor makes sales that are exempt from sales taxes, then the independent distributor must obtain a valid exemption certificate from the purchaser to evidence the transaction and provide a copy of the completed exemption certificate to the multilevel marketer who has the multilevel marketer agreement with the department.

4.1(7) *Legislative changes.* All multilevel marketer agreements are subject to all applicable legislative enactments which are made subsequent to the agreement and which impact the agreement.

These rules are intended to implement Iowa Code section 421.5 and section 421.17 as amended by 2000 Iowa Acts, House File 2562, section 1.

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701—15.12(422,423) Excise tax included in and excluded from gross receipts.

15.12(1) An excise tax which is not an Iowa sales or use tax may be excluded from the gross receipts or purchase price of the sale or use of property or taxable services only if all of the following conditions exist:

a. The excise tax is imposed upon the identical sale which the Iowa sales tax is imposed upon or upon the sale which measures the taxable use or upon a use identical to the Iowa taxable use and not upon some event or activity which precedes or occurs after the sale or use.

b. The legal incidence of the excise tax falls upon the purchaser who is responsible for payment of the Iowa sales tax. The purchaser must be obligated to pay the excise tax either directly to the government in question or to another person (e.g., the retailer) who acts as a collector of the tax. See *Gurley v. Rhoden,* 421 U.S. 200, 95 S. Ct. 1605, 44 L.Ed.2d 110 (1975) for a description of the circumstances under which the legal, as opposed to the economic, burden of an excise tax falls upon the purchaser.

c. The name of the tax is specifically stated and the amount of the tax separately set out on the invoice, bill of sale, or upon another document which embodies a record of the sale.

EXAMPLE 1. The federal government imposes an excise tax upon the act of manufacturing tangible personal property within the United States. The amount of the tax is measured as a percentage of the price for the first sale of the property, which is usually to a wholesaler. However, one particular manufacturer sells its manufactured goods at retail in Iowa. Even if this tax meets the requirements for exclusion of paragraphs *"b"* and *"c"* above, it is not excludable because it does not meet the requirements of paragraph *"a."* The tax is not imposed upon the act of sale but upon the prior act of manufacture. The tax is merely measured by the amount of the proceeds of the sale.

EXAMPLE 2. The federal government imposes an excise tax of 4 percent on a retailer's gross receipts from sales of tangible personal property. The law allows the retailer to separately identify and bill a customer for the tax. However, if a retailer fails to pay the tax, the government cannot collect it from a purchaser and if the government assesses tax against the retailer and secures a judgment requiring the retailer to pay the tax, the retailer who has failed to collect the tax from a purchaser on the initial sale has no right of reimbursement from the purchaser. This tax is not excludable from Iowa excise tax. Its economic burden falls upon the purchaser. However, since neither the government nor the retailer has any legal right to demand payment of the tax from a purchaser, the legal incidence of the tax is not upon the purchaser; and the tax would not meet the requirements of paragraph *"b"* above.

15.12(2) As of January 1, 1988, the following federal excise taxes are includable in the gross receipts of Iowa sales tax:

a. The federal gallonage taxes on distilled spirits, wines, and beer imposed by 26 U.S.C. Sections 5001, 5041, and 5051.

b. The tax imposed by 26 U.S.C. Section 5701 with regard to cigars, cigarettes, and cigarette papers and tubes.

c. The federal tax on gasoline imposed under 26 U.S.C. Section 4081.

d. The federal tax on tires, inner tubes, and tread rubber imposed by 26 U.S.C. Section 4071.

e. The federal manufacturer's excise tax imposed by 26 U.S.C. Section 4061 has been repealed.

15.12(3) The following excise taxes are excluded from the amount of gross receipts:

a. The federal tax imposed by 26 U.S.C. Section 4251(a) on the communication services of local telephone service, toll telephone service, and teletypewriter exchange service.

b. The federal tax imposed by 26 U.S.C. Section 4051 upon the first retail sale of automobile and truck chassis and bodies; truck trailer and semitrailer chassis and bodies and tractors of the kind chiefly used for highway transportation in combination with trailers or semitrailers.

This rule is intended to implement Iowa Code sections 422.42(6), 422.43, 423.1, and 423.2.

701—15.13(422,423) Freight, other transportation charges, and exclusions from the exemption applicable to these services. The determination of whether freight and other transportation charges shall be subject to sales or use tax is dependent upon the terms of the sale agreement.

When tangible personal property or a taxable service is sold at retail in Iowa or purchased for use in Iowa and under the terms of the sale agreement the seller is to deliver the property to the buyer or the purchaser is responsible for delivery and such delivery charges are stated and agreed to in the sale agreement or the charges are separate from the sale agreement, the gross receipts derived from the freight or transportation charges shall not be subject to tax. As of May 20, 1999, this exemption does not apply to the service of transporting electrical energy. As of April 1, 2000, this exemption does not apply to the service of transporting natural gas.

When freight and other transportation charges are not separately stated in the sale agreement or are not separately sold, the gross receipts from the freight or transportation charges become a part of the gross receipts from the sale of tangible personal property or a taxable service and are subject to tax. Where a sales agreement exists, the freight and other transportation charges are subject to tax unless the freight and other transportation charges are separately contracted. If the written contract contains no provisions separately itemizing such charge, tax is due on the full contract price with no deduction for transportation charge, regardless of whether or not such transportation charges are itemized separately on the invoice. *Clarion Ready Mixed Concrete Company v. Iowa State Tax Commission,* 252 Iowa 500, 107 N.W.2d 553(1961); *Schemmer v. Iowa State Tax Commission,* 254 Iowa 315, 117 N.W.2d 420(1962); *City of Ames v. Iowa State Tax Commission,* 246 Iowa 1016, 71 N.W.2d 15(1959); *Dain Mfg. Company v. Iowa State Tax Commission,* 237 Iowa 531, 22 N.W.2d 786(1946).

The exclusions from this exemption relating to the transportation of natural gas and electricity are applicable to all contracts for the performance of these transportation services. Below are examples which explain some of the principal circumstances in which the transport of natural gas or electricity is a service subject to tax.

EXAMPLE 1. Consumer ABC, located in Des Moines, contracts with supplier DEF, located in Waterloo, for DEF to sell gas and electricity to ABC. ABC then contracts with utility GHI to transport the energy over GHI's network (of pipes or wires) from Waterloo to ABC's facility in Des Moines. GHI's transport of ABC's energy is a taxable service. The transportation of natural gas and electricity by a utility is a taxable service of furnishing natural gas or electricity whether or not that utility or some other utility produces the natural gas or generates the electricity furnished. A utility's transportation of gas or electricity is a "transportation service" specifically excluded from the exemption set out in this rule.

EXAMPLE 2. Consumer ABC contracts with utility DEF for DEF to provide electricity from DEF's generating plant in Mason City to ABC's location in Cedar Rapids. Transport of the electricity is by way of DEF's network of long distance transmission lines. The contract between ABC and DEF states the prices to be paid for the purchase of various amounts of electricity and also sets out the amounts to be paid for transport of electricity as well and constitutes separate sales of electricity and transportation services. In these circumstances, amounts which ABC pays DEF for transport of the electricity are taxable gross receipts. This transportation service would ordinarily then be excluded from tax under the exemption set out in this rule; however, separate transportation charges for transportation of electricity are excluded from the exemption (as of May 20, 1999, and are thereafter taxable).

EXAMPLE 3. As in Example 2, consumer ABC contracts with utility DEF for the delivery of electricity from DEF's generating plant in Mason City to ABC's location in Cedar Rapids, ownership of the electricity to pass to ABC in Cedar Rapids. Also, as in Example 2, the contract between ABC and DEF states varying prices to be paid for the purchase and transportation of varying amounts of electricity and constitutes separate sales of electricity and transportation services. Transport of the electricity will be by way of GHI's transmission lines. DEF contracts with GHI for the transport of the electricity to ABC's plant in Cedar Rapids. At the time the contract is signed, GHI asks DEF for an exemption certificate stating that DEF will resell GHI's transportation service to ABC. GHI must either secure the certificate or collect Iowa sales tax from DEF. GHI is furnishing a taxable electricity transportation service to DEF which DEF will in turn furnish to ABC. DEF must collect tax from ABC.

EXAMPLE 4. In this example, the same contract exists between ABC and DEF as exists in Example 3. However, in this example, a breakdown at DEF's plant in Mason City prevents DEF from generating the electricity which it is contractually obligated to provide to ABC. DEF is forced to purchase both electricity and its transport from JKL. The contract between DEF and JKL states the prices to be paid for the purchase of various amounts of electricity and also sets out the amounts to be paid for the transport of this electricity as well and constitutes separate sales of electricity and transportation services. JKL asks DEF for an exemption certificate stating that DEF has purchased the electricity and its transport for resale to ABC. In this case, JKL must secure an exemption certificate from DEF to avoid collecting tax on its sale and transport of the electricity for DEF.

EXAMPLE 5. Again, ABC and DEF have contracted, as they did in Example 2, for DEF to sell and transport electricity from Mason City to Cedar Rapids. However, their agreement mentions only one combined price for sale and delivery of the electricity. There is no separately contracted price for transport of the electricity, in contrast to the situation in Example 2. In this case, the entire amount which ABC pays to DEF is taxable as the entire amount paid is for the sale of tangible personal property. See Clarion Ready Mixed and Schemmer, generally, above.

EXAMPLE 6. Manufacturer EFG contracts with utility DEF for the purchase of natural gas with a separate contract for its delivery. The gas is to be transported from DEF's storage facility near Osceola to EFG's manufacturing plant in Fort Dodge by way of DEF's pipeline. Ownership of the gas passes from DEF to EFG in Fort Dodge. EFG uses 92 percent of the gas which is transported to its plant in processing the goods manufactured there. The receipts which EFG pays DEF for the transport of the gas are excluded from the transportation exemption, but they are not excluded from the processing exemption. Ninety-two percent of those receipts are exempt from tax because that is the percentage of gas used by EFG in processing.

This rule is intended to implement Iowa Code sections 422.43 and 423.2 and Iowa Code section 422.45(2) as amended by 1999 Iowa Acts, chapter 151.

701—15.14(422,423) Installation charges when tangible personal property is sold at retail. When the sale of tangible personal property includes a charge for installation of the personal property sold, the current rate of tax shall be measured on the entire gross receipts from the sale. The installation charges would not be taxable if: (1) The installation service is not an enumerated service, and also (2) where a sales agreement exists, the installation charges are separately contracted. If the written contract contains no provisions separately itemizing such charges, tax is due on the full contract price with no deduction for installation charges, regardless whether or not such installation charges are itemized separately on the invoice.

If the installation services are enumerated services, the installation charges would not be taxable if: (1) The services are exempt from tax, e.g., the services are performed on or connected with new construction, reconstruction, alteration, expansion or remodeling of a building or structure; or, the services are rendered in connection with the installation of new industrial machinery or equipment. See rule 701—19.13(422, 423) and subrule 18.45(7), respectively. And also (2) where a sales agreement exists, the installation charges are separately contracted. If the written contract contains no provisions separately itemizing such charges, tax is due on the full contract price with no deduction for installation charges, regardless whether or not such installation charges are itemized separately on the invoice. If no written contract exists, the installation charges must be separately itemized on the invoice to be exempt from tax.

This rule is intended to implement Iowa Code sections 422.43 and 423.2.

701—15.15(422) Premiums and gifts. A person who gives away or donates tangible personal property shall be deemed to be a consumer of such property for tax purposes. The gross receipts from the sale of tangible personal property to such persons for such purposes shall be subject to tax.

When a retailer purchases tangible personal property, exclusive of tax, for the purpose of resale in the regular course of business and later gives it away or donates it, the retailer shall include in the return the value of the property at the retailer's cost price.

When a retailer sells tangible personal property and furnishes a premium with the property sold, the retailer is considered to be the ultimate consumer or user of the premium furnished.

This rule is intended to implement Iowa Code sections 422.42 and 422.43.

701—15.16(422) Gift certificates. When a retailer sells gift certificates, tax shall be added at the time the gift certificate is redeemed.

This rule is intended to implement Iowa Code sections 422.42 and 422.43.

701—15.17(422,423) Finance charge. Interest or other types of additional charges that result from selling on credit or under installment contracts are not subject to sales tax when such charges are separately stated and when such charges are in addition to an established cash selling price. However, if a sale is made for a lump sum, the tax is due on the total selling price if finance charges are not separately stated.

When interest and other types of additional charges are added as a condition of a sale in order to obtain title rather than as a charge to obtain credit where title to goods has previously passed, such charges will be subject to tax even though they may be separately stated. *State ex. rel. Turner v. Younkers Bros., Inc.,* 210 N.W.2d 550 (Iowa 1973); *Road Machinery Supplies of Minneapolis, Inc., v. The Commissioner of Revenue,* Minnesota Tax Court of Appeals, 1977, 2 Minn. CCH State Tax Reporter II 200-835. See rule 701—16.47(422,423) relating to conditional sales contracts.

This rule is intended to implement Iowa Code sections 422.42(2) and 423.4.

701—15.18(422,423) Coins and other currency exchanged at greater than face value. Any exchange, transfer, or barter of merchandise for a consideration paid in gold, silver, or other coins or currency shall be subject to tax to the extent of the agreed-upon value of the coins or currency so exchanged. This agreed-upon value constitutes the gross receipts or purchase price subject to tax. Coins or currency becomes articles of tangible personal property having a value greater than face value when they are exchanged for a price greater than face value. However, when a coin or other currency, in the course of circulation, is exchanged at its face value, the sale shall be subject to tax for the face value alone. *Losana Corp. v. Porterfield,* 14 Ohio St.2d 42, 236 N.E.2d 535 (1968).

15.19(4) All the provisions of subrule 15.19(2) apply to the trade-in of vehicles subject to registration when the trade involves retailers of vehicles.

When vehicles subject to registration are traded between persons neither of which is a retailer of vehicles subject to registration, the conditions set forth in 15.19(2) *"a"* and *"b"* need not be met. The purchase price is only that portion of the purchase price represented by the difference between the total purchase price of the vehicle subject to registration acquired and the amount of the vehicle subject to registration traded.

EXAMPLE: John Doe has an automobile with a value of $2,000. John and his neighbor Bill Jones, who has an automobile valued at $3,500, decide to trade automobiles. John pays Bill $1,500 cash. Vehicles subject to registration are subject to use tax which is payable to the County Treasurer at the time of registration. In this example John would owe use tax on $1,500 since this is the amount John paid Bill and tax is only due on the cash difference. Bill would not owe any use tax on the vehicle acquired through the trade.

EXAMPLE: Joe has a Ford automobile with a value of $5,000. Joe and his friend Jim who has a Chevrolet automobile also valued at $5,000 decide to trade automobiles. Joe and Jim make an even trade, automobile for automobile with no money changing hands. In this example there is no tax due on either automobile because there is no exchange of money.

15.19(5) The trade-in provisions found in Iowa Code sections 422.42(6)*"b"* and 423.1(3) do not apply to taxable enumerated services. Where taxable enumerated services are traded, the gross receipts would be determined based on the value of the service.

This rule is intended to implement Iowa Code sections 422.42(6)*"b"* and 423.1(3). See also *Reynolds Motor Co. et al v. Iowa Dep't. of Revenue,* Equity 72050, Dist. Ct. of Scott Cty., Iowa, August 28, 1987.

701—15.20(422,423) Corporate mergers which do not involve taxable sales of tangible personal property or services. If title to or possession of tangible personal property or ownership of services is transferred from one corporation to another pursuant to a statutory merger, the transfer is not a "sale" subject to tax if all of the following circumstances exist: (1) the merger is pursuant to statute (for example, Iowa Code section 490.1106); (2) by the terms of that statute, the title or possession of property or services transferred passes from a merging corporation to a surviving corporation and not for any consideration; and (3) the merging corporation is extinguished and dissolved the moment the merger occurs and, as a result of this dissolution, cannot receive any benefit from the merger. Transactions which are not of the type described above may involve taxable sales. See the following court cases relating to this area: *Nachazel v. Mira Co. Mfg.,* 466 N.W.2d 248 (Iowa 1991); *D. Canale & Co. v. Celauro,* 765 S.W.2d 736 (Tenn 1989); and *Commissioner of Revenue v. SCA Disposal Services,* 421 N.E.2d 766 (Mass 1981).

EXAMPLE A: Nonaffiliated Corporations A and C enter into a voluntary merger agreement governed by Iowa Code section 490.1106. A and C are separate and independent, one from the other, and neither is a subsidiary of another corporation. No officer of the one is an officer of the other. A and C voluntarily negotiate an arms-length merger agreement which results in the transfer of A's assets to C and the dissolution of A. In return, A's stockholders receive stock in C. A's transfer of tangible personal property to merged company C is not subject to sales or use tax.

EXAMPLE B: Corporations B, D, and E are independent entities. They enter into a merger agreement governed by Iowa Code section 490.1106 and agree to merge into one surviving corporation which will (after the dissolution of B and D) be E. They agree that the shares of merging corporations will be converted into shares of E on an equal basis. The transfers of property by the corporations which are parties to the merger are not sales subject to Iowa tax.

EXAMPLE C: Corporation F receives all of Corporation G's outstanding shares from G's sole stockholder. In return, G's sole stockholder receives stock from F. Corporation G continues to exist after the transaction as a subsidiary of Corporation F. This particular transaction involves a trade or barter of the stock shares of F and G. There is a barter of the stocks and thus a "sale" as that term is understood for the purposes of Iowa sales tax law. However, because the sale involves only intangible property (the stock shares), that sale is not taxable. The stock exchange transaction would not prevent taxation of subsequent transfers of tangible personal property or services between F and G.

EXAMPLE D: Corporation H buys all the assets of Corporation I which include machinery, equipment, finished goods, and raw materials. Corporation H pays cash for these assets. This transaction does involve the sale of tangible personal property and may be subject to Iowa sales tax. However, see 701—subrule 18.28(2) concerning a casual sale exemption applicable to the liquidation of a business.

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CHAPTER 71
ASSESSMENT PRACTICES AND EQUALIZATION
[Prior to 12/17/86, Revenue Department[730]]

701—71.1(405,427A,428,441,499B) Classification of real estate.

71.1(1) *Responsibility of assessors.* All real estate subject to assessment by city and county assessors shall be classified as provided in this rule. It shall be the responsibility of city and county assessors to determine the proper classification of real estate. 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, and structures containing three or more separate living quarters shall not be considered residential real estate. However, regardless of the number of separate living quarters, multiple housing cooperatives organized under Iowa Code chapter 499A and land and buildings owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be considered residential real estate.

An apartment in a horizontal property regime (condominium) referred to in Iowa Code chapter 499B which is used or intended for use for human habitation shall be classified as residential real estate regardless of who occupies the apartment. Existing structures shall not be converted to a horizontal property regime unless building code requirements have been met.

71.1(5) *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, 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.

An apartment in a horizontal property regime (condominium) referred to in Iowa Code chapter 499B which is used or intended for use as a commercial venture, other than leased for human habitation, shall be classified as commercial real estate. Existing structures shall not be converted to a horizontal property regime unless building code requirements have been met.

71.1(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, 441.22 and chapter 499B as amended by 2000 Iowa Acts, Senate File 2426.

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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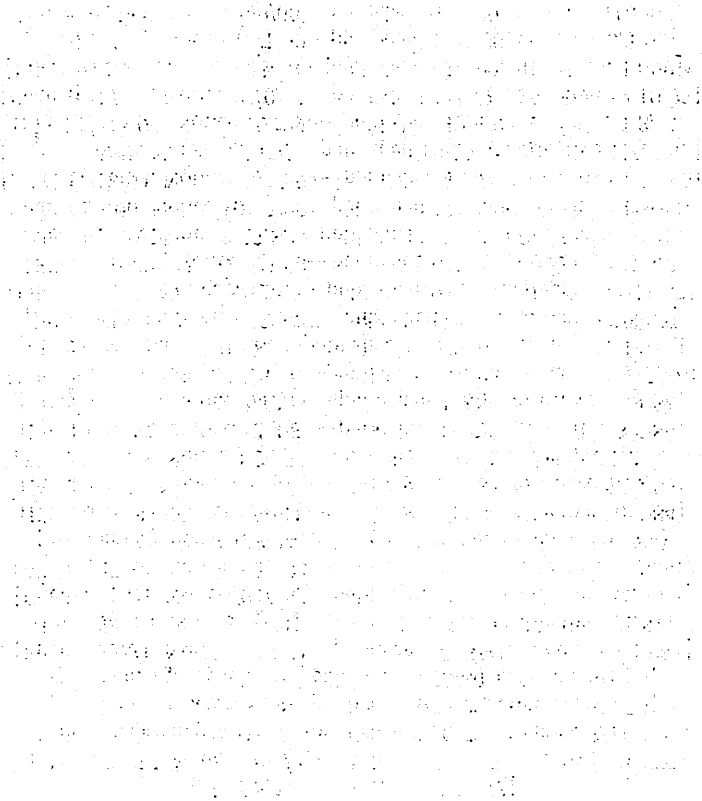

CHAPTER 74
MOBILE, MODULAR, AND MANUFACTURED HOME TAX
[Prior to 12/17/86, Revenue Department[730]]

701—74.1(435) Definitions.

1. *"Mobile home"* means any vehicle without motive power used or so manufactured or constructed as to permit its being used as a conveyance upon the public streets and highways and so designed, constructed, or reconstructed as will permit the vehicle to be used as a place for human habitation by one or more persons; but shall also include any such vehicle with motive power not registered as a motor vehicle in Iowa. A "mobile home" is not built to a mandatory building code, contains no state or federal seals, and was built before June 15, 1976.

2. *"Manufactured home"* is a factory-built structure built under authority of 42 U.S.C. § 5403, is required by federal law to display a seal from the United States Department of Housing and Urban Development, and was constructed on or after June 15, 1976.

3. *"Modular home"* means a factory-built structure which is manufactured to be used as a place of human habitation, is constructed to comply with the state of Iowa building code for modular factory-built structures, and must display the seal issued by the state building code commissioner.

4. *"Mobile home park"* means any land upon which three or more mobile or manufactured homes, or a combination of such homes, are placed on developed spaces and operated as a for-profit enterprise with water, sewer or septic, and electrical services available. It does not include homes where the owner of the land is providing temporary housing for the owner's employees or students.

Wherever used in this chapter, "home" means a mobile home, a manufactured home, or a modular home unless specific reference is made to a particular type of home.

This rule is intended to implement Iowa Code section 435.1 as amended by 1998 Iowa Acts, Senate File 2400.

701—74.2(435) Movement of home to another county. If one or both installments of the tax for the current fiscal year have been paid and subsequently the home is moved to another county, the tax paid shall remain in the county in which originally collected. No reimbursement shall be made either to the owner of the home or to the county to which the home is moved. If only the first installment has been paid and the home is moved prior to January 1, the second installment shall be made to the county to which the home is moved.

This rule is intended to implement Iowa Code section 435.22.

701—74.3(435) Sale of home. If the owner of a home has paid one or both installments of the tax for the current fiscal year and subsequently sells the home, no reimbursement shall be made to the seller for any portion of the tax paid. If only the first installment has been paid and the home is sold prior to January 1, the purchaser is responsible for the second installment.

This rule is intended to implement Iowa Code section 435.22.

701—74.4(435) Reduced tax rate.

74.4(1) *Claimant.* The reduced rate of tax for Iowa residents who were at least 23 years of age on December 31 of the base year shall be computed as provided in Iowa Code subsection 435.22(2). The claimant's name must appear on the title to the home.

74.4(2) *Income.* In determining eligibility for the reduced tax rate, the claimant's income and that of the claimant's spouse shall be the income received during the base year, or the income tax accounting period ending during the base year, and must be less than the indexed amount determined pursuant to Iowa Code section 435.22(2). The base year is the calendar year immediately preceding the year in which the claim is filed.

74.4(3) *Claims.* Claims for the reduced tax rate must be filed with the county treasurer on or before June 1 immediately preceding the fiscal year during which the taxes are due. The county treasurer may extend the time for filing a claim for reduced tax rate through September 30 of the same year. The director of revenue and finance may also extend the time for filing a claim through December 31 if good cause exists. Late reduced tax rate claims will be reimbursed by the director directly to the claimant upon proof of tax payment. The claimant must own and occupy the home at the time the claim for credit is filed or, if deceased, at the time of the claimant's death or, if a late claim, on June 1 of the claim year. The claim forms shall be provided by the department of revenue and finance.

74.4(4) *Reports to department of revenue and finance.* On or before November 15 of each year, the county treasurer of each county shall report to the department of revenue and finance the amount of taxes not to be collected for the current fiscal year as a result of the reduced tax rate provided in Iowa Code subsection 435.22(2). All reports shall be made on forms provided by the department of revenue and finance.

74.4(5) *Payment of claims.* On December 15 of each year the department of revenue and finance shall remit to each county treasurer an amount equal to the taxes not collected during the current fiscal year as a result of the granting of the reduced tax rate.

This rule is intended to implement Iowa Code section 435.22 as amended by 1999 Iowa Acts, chapter 152, and is effective for reduced tax rate claims filed on or after January 1, 2000.

701—74.5(435) Taxation—real estate. Homes located outside of mobile home parks must be placed on a permanent foundation and are subject to assessment and taxation as real estate. The homes are eligible for all property tax credits and exemptions applicable to other real estate. The assessor shall collect the title to a home only when a security interest is noted on the title and the secured party is given a mortgage on the land on which the home is located. Homes located outside mobile home parks as of July 1, 1994, are not subject to the permanent foundation requirements unless the home is relocated. The homes are subject to assessment as real estate beginning January 1, 1995.

This rule is intended to implement Iowa Code section 435.26 as amended by 1994 Iowa Acts, chapter 1110.

701—74.6(435) Taxation—square footage. Homes located within mobile home parks are subject to a square footage tax at the rates specified in Iowa Code section 435.22. It shall be the responsibility of the owner to provide the county treasurer with appropriate documentation to verify eligibility for the reduced tax due to the home's age. Modular homes placed in mobile home parks that were not in existence on or before January 1, 1998, shall be subject to assessment and taxation as real estate.

The mobile home park owner or manager shall make an annual report with the county treasurer by June 1 listing the owner and address of each home sited in the park. An additional report shall be filed by December 1 if any homes move in or out of the park or there are any changes in home ownership.

This rule is intended to implement Iowa Code section 435.22 and section 435.24(3) as amended by 2000 Iowa Acts, Senate File 2253.

701—74.7(435) Audit by department of revenue and finance. The director of revenue and finance may audit the books and records of the county treasurer to determine if the amounts certified by the county treasurer to the director of revenue and finance as tax not collected due to the reduced tax rate are true and correct. Upon investigation, the director of revenue and finance may order the county treasurer to reimburse the state of Iowa any amounts that were erroneously paid to the county treasurer. The director of revenue and finance may also require that additional payments be made to the county treasurer by the owner of a home if investigation reveals that the county treasurer did not receive the full amounts due in accordance with Iowa Code section 435.22.

The director of revenue and finance may initiate investigations or assist the county treasurer's investigations into eligibility of a claimant for the reduced tax rate in accordance with Iowa Code section 435.22. Upon investigation, the director of revenue and finance may order a claimant to reimburse the state of Iowa any amount erroneously claimed as a reduced tax rate which was reimbursed by the department of revenue and finance to the county treasurer in accordance with Iowa Code section 435.22. The director of revenue and finance may also issue a reimbursement directly to the claimant if it is determined the claimant did not receive the full benefits to which entitled pursuant to Iowa Code section 435.22.

This rule is intended to implement Iowa Code section 435.22.

701—74.8(435) Collection of tax.

74.8(1) *Partial payment of tax.* Partial payments of taxes may be allowed at the discretion of the county treasurer. If the treasurer elects to permit partial payments, the authorization shall apply to all taxpayers within the county. The treasurer may establish a minimum payment amount that must be made for partial payments to be accepted. If the partial payments made are insufficient to fully satisfy an installment due by the delinquency date, the unpaid portion of the installment shall draw interest as provided in Iowa Code section 445.39. Current year taxes may be paid at any time regardless of any prior year delinquent taxes. The minimum payment for delinquent taxes must be equal to or exceed the interest, fees, and costs attributed to the oldest delinquent installment due.

74.8(2) *When delinquent.* The date on which unpaid taxes become delinquent is to be determined as follows:

a. If the home is put to use between January 1 and March 31, the prorated tax for the period from the date the home is put to use through June 30 becomes delinquent on April 1.

b. If the home is put to use between April 1 and June 30, the prorated tax for the period from the date the home is put to use through June 30 becomes delinquent on October 1.

c. If the home is put to use between July 1 and September 30, the prorated tax for the period from the date the home is put to use through December 31 becomes delinquent on October 1.

d. If the home is put to use between October 1 and December 31, the prorated tax for the period from the date the home is put to use through December 31 becomes delinquent on April 1 of the following calendar year.

e. For purposes of this rule, a home is "put to use" upon its acquisition from a dealer or its being brought into Iowa for immediate use by a person who is not engaged in the business of manufacturing, sale, or transportation of homes.

74.8(3) *Collection of delinquent tax.* Delinquent taxes shall be collected by offering the home at tax sale in accordance with Iowa Code chapter 446.

This rule is intended to implement Iowa Code sections 435.24 and 435.25 and Iowa Code section 445.37 as amended by 1995 Iowa Acts, Senate File 458.

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80.11(3) *Application of credit.* The county auditor shall apply the credit to each eligible tract of land in an amount equal to the school district tax rate which is in excess of $5.40 multiplied by the taxable value of the eligible tract.

This rule is intended to implement Iowa Code chapter 425A as amended by 1996 Iowa Acts, House File 560.

701—80.12(427) Methane gas conversion property.

80.12(1) *Application for exemption.* An application for exemption is required to be filed with the appropriate assessing authority by February 1 of each year. The assessed value of the property is to be prorated to reflect the appropriate amount of exemption if the property used to convert the methane gas to energy also uses another fuel. The first year exemption shall be equal to the estimated ratio that the methane gas consumed bears to the total fuel consumed times the assessed value of the property. The exemption for subsequent years shall be based on the actual ratio for the previous year.

80.12(2) *Eligibility for exemption.* To qualify for exemption, the property must be used in connection with a publicly owned sanitary landfill where methane gas is produced as a byproduct of waste decomposition and converted to energy.

This rule is intended to implement Iowa Code section 427.1(43).

701—80.13(427B) Wind energy conversion property. A city council or county board of supervisors may provide by ordinance for the special valuation of wind energy conversion property. If the ordinance is repealed, the special valuation applies through the nineteenth assessment year following the first year the property was assessed. The special valuation applies to property first assessed on or after the effective date of the ordinance. The local assessor shall value the property in accordance with the schedule provided in Iowa Code Supplement section 427B.26(2). Public utility property qualifies for special valuation provided the taxpayer files a declaration of intent with the local assessor by February 1 of the assessment year the property is first assessed for tax to have the property locally assessed.

This rule is intended to implement Iowa Code section 427B.26.

701—80.14(427) Mobile home park storm shelter.

80.14(1) *Application for exemption.* An application for exemption must be filed with the assessing authority by April 15 of the first year the exemption is requested. Applications for exemption are not required in subsequent years if the property remains eligible for exemption.

80.14(2) *Eligibility for exemption.* The structure must be located in a mobile home park as defined in Iowa Code section 435.1.

80.14(3) *Valuation exempted.* If the structure is used exclusively as a storm shelter, it shall be fully exempt from taxation. If not used exclusively as a storm shelter, the exemption shall be limited to 25 percent of the structure's valuation.

This rule is intended to implement Iowa Code section 427.1 as amended by 1999 Iowa Acts, chapter 186, section 3.

701—80.15(427) Barn and one-room schoolhouse preservation. The increase in value added to a farm structure constructed prior to 1937 or one-room schoolhouse as a result of improvements made is exempt from tax. An application must be filed with the assessor by February 1 of the first assessment year only and the exemption is to continue as long as the structure continues to be used as a barn or in the case of a one-room schoolhouse is not used for dwelling purposes. A "barn" is an agricultural structure that is used for the storage of farm products or feed or the housing of farm animals, poultry, or farm equipment.

This rule is intended to implement Iowa Code sections 427.1(31) and 427.1(32) as amended by 2000 Iowa Acts, House File 2560.

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701—81.6(453A) Audit of records—cost, supplemental assessments and refund adjustments. The department shall have the right and duty to examine or cause to be examined the books, records, memoranda or documents of a taxpayer for the purpose of verifying the correctness of a return or report filed or determining the tax liability of any taxpayer under Iowa Code chapter 453A.

When it is determined, upon audit, that any person dealing in cigarettes owes additional tax, the costs of the audit are assessed against such person as additional penalty.

The department may, at any time within the period prescribed for assessment or refund adjustment, make a supplemental assessment or refund adjustment whenever it is ascertained that any assessment or refund adjustment is imperfect or incomplete in any respect.

If an assessment or refund adjustment is appealed (protested under rule 701—7.41(17A)) and is resolved whether by informal proceedings or by adjudication, the department and the taxpayer are precluded from making a supplemental assessment or refund adjustment concerning the same issue involved in such appeal for the same tax period unless there is a showing of mathematical or clerical error or a showing of fraud or misrepresentation.

This rule is intended to implement Iowa Code section 453A.30.

701—81.7(453A) Bonds. When bonds are required by Iowa Code chapter 453A or these rules, said bonds shall be in the form of cash, a certificate of deposit or a bond issued by a surety company licensed to do business in the state of Iowa, payable to the state of Iowa and in a form approved by the director. Bonds required by tobacco distributors must be issued by a surety company licensed to do business in Iowa. However, upon approval by the director, a cash bond or a certificate of deposit will be accepted by the department as a substitute for the surety bond. (See Iowa Code section 453A.44(4).)

This rule is intended to implement Iowa Code sections 453A.14 and 453A.44.

701—81.8(98) Penalties. Renumbered as 701—10.76(98), IAB 1/23/91.

701—81.9(98) Interest. Renumbered as 701—10.77(98), IAB 1/23/91.

701—81.10(98) Waiver of penalty or interest. Renumbered as 701—10.78(98), IAB 1/23/91.

701—81.11(453A) Appeal—practice and procedure before the department.

81.11(1) *Procedure.* The practice and procedure before the department is governed by Iowa Code chapter 17A and 701—Chapter 7 of the department's rules.

81.11(2) *Appeals—time limitations.* For assessments or denials of refund claims made on or after July 1, 1987. An assessment or denial of all or any portion of a refund claim issued pursuant to Iowa Code section 453A.28 or 453A.46 may be appealed pursuant to rule 701—7.41(17A) and the protest must be filed within 30 days of the issuance of the assessment or denial of the refund claim. For notices of assessment or refund denial issued on or after January 1, 1995, the department will consider a protest to be timely filed if filed no later than 60 days following the date of the assessment notice or refund denial, or if a taxpayer failed to timely appeal a notice of assessment, the taxpayer may make payment pursuant to rule 701—7.41(17A) and file a refund claim within the period provided by law for filing such claims.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 453A.25, 453A.28, 453A.29, 453A.46, 453A.48, and 453A.49.

701—81.12(453A) Permit—license revocation.

81.12(1) *Cigarette permits.* Cigarette permits issued by the department must be revoked if the permittee willfully violates the provisions of Iowa Code section 453A.2 (sale or gift to minors). The department may revoke permits issued by the department for violation of any other provision of division I of Iowa Code chapter 453A or the rules promulgated thereunder. (Also see Iowa Code chapter 421B and rule 701—84.7(421B).) The revocation shall be subject to the provisions of rule 701—7.55(17A). The notice of revocation shall be given to the permittee at least ten days prior to the hearing provided therein. The department will revoke a permit of a permit holder, who is an individual, if the department has received a certificate of noncompliance from the child support unit in regard to the permit holder, unless the unit furnishes the department with a withdrawal of the certificate of noncompliance.

The board of supervisors or the city council that issued a retail permit is required by Iowa Code section 453A.22 to revoke the permit of any retailer violating Iowa Code section 453A.2 (sale or gift to minors). The board or council may revoke a retail permit for any other violation of division I of Iowa Code chapter 453A. The revocation procedures are governed by Iowa Code section 453A.22(2) and the individual council's or board's procedures. Iowa Code chapter 17A does not apply to boards of supervisors or city councils. (See rule 701—84.7(421B).) The board of supervisors or the city council that issued a retail permit is required by Iowa Code chapter 252J to revoke the permit of any retailer, who is an individual, if the board or council has received a certificate of noncompliance from the child support recovery unit in regard to the retailer, unless the unit furnishes the board of supervisors or the city council with a withdrawal of the certificate of noncompliance.

If a permit is revoked under this subrule, except for the receipt of a certificate of noncompliance from the child support recovery unit, the permit holder cannot obtain a new cigarette permit of any kind nor may any other person obtain a permit for the location covered by the revoked permit for a period of one year unless good cause to the contrary is shown to the issuing authority. If a retail permit is suspended or revoked, the suspension or revocation applies only to the place of business where the violation occurred and not to any other place of business covered by the permit.

The department or local authority must report the suspension or revocation of a retail permit to the department of public health within 30 days of the suspension or revocation.

81.12(2) *Tobacco licenses.* The director may revoke, cancel or suspend the license of any tobacco distributor or tobacco subjobber for violation of any provision in division II of Iowa Code chapter 453A, the rules promulgated thereunder, or any other statute applicable to the sale of tobacco products. The licensee shall be given ten days' notice of a revocation hearing under Iowa Code section 453A.48(2) and rule 701—7.55(17A). No license may be issued to any person whose license has been revoked under Iowa Code section 453A.44(11) for a period of one year. The department will revoke a license of a licensee, who is an individual, if the department has received a certificate of noncompliance from the child support recovery unit in regard to the licensee, unless the unit furnishes the department with a withdrawal of the certificate of noncompliance.

This rule is intended to implement Iowa Code sections 453A.13 and 453A.22 as amended by 2000 Iowa Acts, Senate File 2366, and sections 453A.44(11) and 453A.48(2).

701—81.13(453A) Permit applications and denials.

81.13(1) *Applications for permits.* The application forms for all permits issued under Iowa Code chapter 453A are available from the department upon request. The applications shall include, but not be limited to:

a. The nature of the applicant's business;

b. The type of permit requested;

c. The address of the principal office of the applicant;

d. The place of business for which the permit is to apply;

This rule is intended to implement Iowa Code sections 453A.6, 453A.40, and 453A.43.

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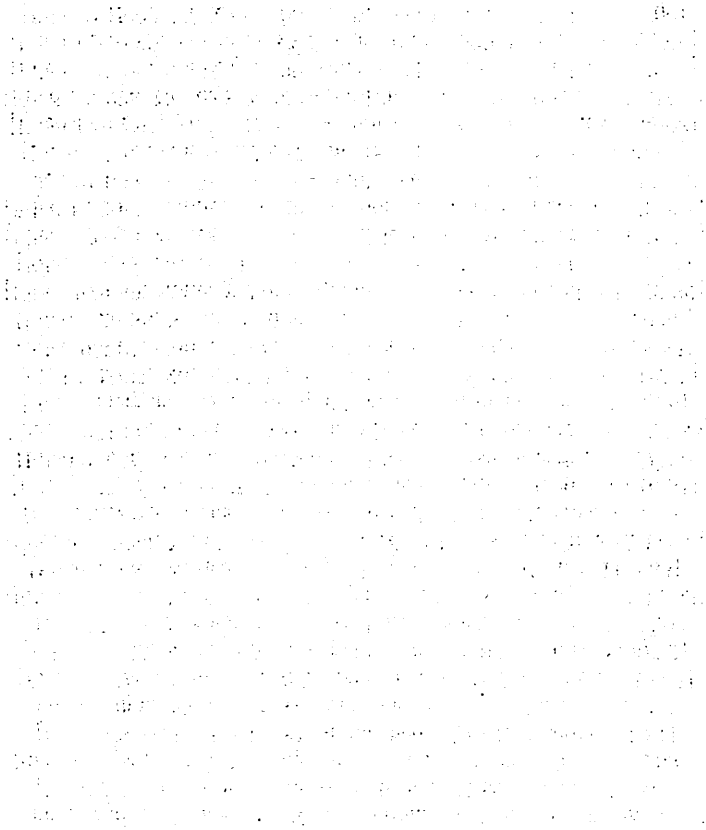

CHAPTER 82
CIGARETTE TAX
[Prior to 12/17/86, Revenue Department[730]]

701—82.1(453A) Permits required. Every person selling or distributing cigarettes or using or consuming untaxed cigarettes within the state of Iowa must first obtain the appropriate permit.

82.1(1) *Distributor's permit.* Every person acting as a distributor as defined in Iowa Code section 453A.1 must obtain a permit from the department. A distributor is any person who obtains unstamped cigarettes within or without this state by manufacture, production, import or by any means for the purpose of making the first intrastate sale or distribution or the first use or consumption in Iowa. Every distributor holding a distributor's permit will cause to be affixed, within or without Iowa, all cigarette tax stamps or meter impressions as set forth in rule 82.8(453A) and Iowa Code section 453A.10. The distributor permit expires annually on June 30, and costs $100. A distributor must obtain a duplicate permit for each place of business owned or operated by the distributor from which distributor activities are carried on. Duplicate distributor permits may be obtained from the department at an annual cost of $5 for each duplicate permit. A distributor may act as a wholesaler without obtaining a wholesaler's license, but a wholesaler's license may be obtained upon meeting all of the requirements for the issuance of a wholesaler's license. If a distributor performs any other function which requires a license, a separate license must be obtained. If a person is not performing the functions of a distributor, a permit will not be issued.

82.1(2) *Wholesaler's permit.* Every person acting as a wholesaler as defined in Iowa Code section 453A.1 must obtain a wholesaler's permit. A wholesaler is any person, other than a distributor or a distributing agent, who sells or distributes cigarettes within Iowa for resale. A "sale or distribution" of cigarettes connotes a transfer of cigarettes from one person or entity to another person or entity. *Union Oil Co. of California v. State,* 2 Wash. 2d 436, 98 P, 2d 660 (1940); *State v. Nash Johnson and Sons' Farms Inc.,* 263 N.C. 66, 138 S.E. 2d 773 (1964). Therefore, an intraentity transfer is not a transaction which qualifies as a function of a wholesaler. The wholesaler permit expires annually on June 30, and costs $100 annually. A wholesaler must obtain a duplicate permit for each place of business owned or operated by the wholesaler from which wholesale activities are carried on. Duplicate wholesaler permits may be obtained from the department at an annual cost of $5 for each duplicate permit. If a person is not performing the functions of a wholesaler, a permit will not be issued.

The following example will illustrate the application of this subrule:

The XYZ Grocery Chain has a warehouse in Des Moines where stamped cigarettes are stored. The stamped cigarettes are purchased from a licensed distributor. XYZ transfers the cigarettes to its retail outlets across the state for the purpose of making retail sales, and makes no other sales. The storage of stamped cigarettes and the retail sale of cigarettes are not functions of a wholesaler, and XYZ would not be eligible for a wholesaler's permit.

82.1(3) *Cigarette vendor's permit.* Every person acting as a cigarette vendor as defined in Iowa Code section 453A.1 must obtain a permit from the department. A cigarette vendor is any person who takes responsibility for furnishing, installing, servicing, operating or maintaining one or more vending machines for the purpose of selling cigarettes at retail, and does so by reason of ownership, agreement or contract.

A retailer who holds a retail permit is not required to get a cigarette vendor's permit if the retail permittee is, in fact, the owner of the cigarette vending machine(s) which is operated in the location described in the retail permit. The cigarette vendor's permit expires annually on June 30, and costs $100 annually. A cigarette vendor must have a duplicate permit for each place of business from which cigarette vending machines are furnished, installed or serviced. A duplicate permit can be obtained from the department for an annual cost of $5. The duplicate permit applies to additional places of business from which the cigarette vendor conducts operations and not to those places of business where the cigarette vending machines are installed for retail sales.

EXAMPLE: A cigarette vendor owns three warehouses from which the vendor supplies cigarettes to 100 vending machines located at various retail establishments. The total permit cost for the vendor would be $110 ($100 for a regular permit plus $10 for two duplicate permits at $5 each).

82.1(4) *Railway retail permit.* A retail permit may be issued to a railway dining car company, railway sleeping car company, railroad or a railway company. A retailer's permit for railway cars is issued by the department for an annual cost of $25 and expires on June 30 of each year. A duplicate permit is required for each car in which cigarettes are stored for sale or sold and each duplicate permit is issued by the department at an annual cost of $2.

82.1(5) *Manufacturer's permit.* Any manufacturer, as defined in Iowa Code section 453A.1, may obtain a manufacturer's permit from the department. A manufacturer is any person who ships cigarettes into this state from outside the state. The permit is issued without cost and is valid until revoked or canceled. The permit allows the manufacturer to purchase tax stamps from the department and to affix such stamps to cigarettes outside of this state prior to their shipment into the state. A manufacturer is required to affix stamps to cigarettes prior to their shipment into this state unless the cigarettes are shipped to an Iowa permitted distributor or an Iowa permitted distributor's agent.

82.1(6) *Distributing agent's permit.* Every person acting as a distributing agent as defined in Iowa Code section 453A.1 must obtain a permit from the department. A distributing agent is any person in this state who acts as an agent of any manufacturer outside of the state by storing cigarettes received in interstate commerce from such manufacturer subject to distribution or delivery to distributors upon orders received from the manufacturer in interstate commerce and transmitted to such distributing agent for fulfillment from such storage place. The distributing agent's permit is issued by the department at an annual cost of $100 and expires on June 30 of each year. A separate permit at the $100 cost must be obtained for each place of business owned or operated within the state by the distributing agent. The permit authorizes the distributing agent to store unstamped cigarettes which are received in interstate commerce for distribution or delivery to distributors upon orders received from outside this state or to be sold outside this state. Stocks of cigarettes held for interstate and intrastate commerce must be kept separate.

82.1(7) *Retailer's permit.*

a. In general. Every person acting as a retailer, as defined in Iowa Code section 453A.1, must obtain a permit. A retailer is any person who:

(1) Directly sells, distributes or offers for sale cigarettes for consumption, or

(2) Possesses cigarettes for direct sale for consumption.

Retail permits are issued by the following authorities at the following prices:

1. Within unincorporated areas of a county, by the county board of supervisors at an annual cost of $50.

2. Within the city limits of a city of less than 15,000 population, by the city council, at an annual cost of $75.

3. Within the city limits of a city equal to or greater than 15,000 population, by the city council, at an annual cost of $100.

The retail permit expires on June 30 of each year. A renewal sticker furnished by the department containing the appropriate year and number may be issued in lieu of a new permit where the place of business of the retail permit holder has remained the same. The retail permit is valid only for the location described in the permit, and a retailer must obtain a separate permit for each place of business owned or operated by the retailer. (See subrule 82.2(3))

The power to grant the retail permit is discretionary with the city council or board of supervisors, and uniform, nondiscriminatory limits may be placed on its issuance. *Bernstein v. City of Marshalltown,* 215 Iowa 1168, 248 N.W. 26 (1933); *Ford Hopkins Co. v. City of Iowa City,* 216 Iowa 1286, 248 N.W. 668 (1933); 1938 O.A.G. 708. The city or county must submit a copy of any retail permit issued and the application for the permit to the department of public health within 30 days of issuance.

b. Mobile retailer. If a cigarette retailer sells cigarettes from a mobile concession vehicle, the vehicle itself shall be considered a place of business. A city has the discretionary power to grant a retail cigarette permit to a place of business located within the corporate limits of that city. A county has the discretionary power to grant a retail cigarette permit to a place of business located within the unincorporated areas of the county. If a retailer is selling cigarettes from a mobile concession vehicle within the area of several permit-issuing authorities, the retailer must obtain a permit from each authority. The retailer is operating a single place of business within the jurisdiction of the several authorities and is, therefore, subject to regulation by each.

The location described on the permit shall include identification of the vehicle and the address of the permanent place of business from which the vehicle is dispatched. If the vehicle is traded in for a new vehicle, the exchange provisions of subrule 82.2(3) shall apply.

This rule is intended to implement Iowa Code section 453A.13 as amended by 2000 Iowa Acts, Senate File 2366, and sections 453A.16, 453A.17, and 453A.23.

701—82.2(453A) Partial year permits—payment—refund—exchange. For purposes of this rule, "year" means the cigarette tax year running from July 1 of year A to June 30 of year B and "quarter" means a yearly quarter with the first quarter commencing on July 1.

82.2(1) *Partial payment.* If any permit is granted other than in the first quarter, the following partial payments are required:

1. During the second quarter - 75 percent of the permit fee.
2. During the third quarter - 50 percent of the permit fee.
3. During the fourth quarter - 25 percent of the permit fee.

82.2(2) *Partial refund.* If any unrevoked permit for which the entire annual fee has been paid is voluntarily surrendered, the following permit fees will be refunded:

1. During the first quarter - 75 percent of the permit fee.
2. During the second quarter - 50 percent of the permit fee.
3. During the third quarter - 25 percent of the permit fee.

If any unrevoked permit for which 75 percent of the annual fee has been paid is voluntarily surrendered, the following permit fees will be refunded by the entity which issued the permit:

1. During the second quarter - 50 percent of the permit fee.
2. During the third quarter - 25 percent of the permit fee.

If any unrevoked permit for which 50 percent of the annual fee has been paid is voluntarily surrendered, the following permit fees will be refunded:

During the third quarter - 25 percent of the annual fee.

82.2(3) *Exchange of permits.* If a permittee changes the location of an operation requiring a permit but remains within the jurisdiction of the same entity which granted the original permit, the permittee may exchange the invalid permit (valid only for the location described in the permit) for a valid permit free of charge, without the partial payment-partial refund process. (1934 O.A.G. 106)

The following nonexclusive examples will illustrate the application of this rule:

EXAMPLE 1: City Bar and Grill sells cigarettes at retail and has obtained a retail cigarette permit from the city of Des Moines. The establishment is moved across the street but remains within the city limits of Des Moines. The retail permit is valid only for the location described in the permit, and therefore, the original permit is no longer valid. However, since the establishment has remained within the jurisdiction of the entity which granted the original permit, Des Moines, the original, presently invalid permit may be exchanged for a valid permit with a new location description at no cost.

EXAMPLE 2: Same as Example 1, except the new location of City Bar and Grill is outside the corporate limits of Des Moines and within the unincorporated area of Polk County. City Bar and Grill would have to surrender the old permit to the city of Des Moines and obtain a new permit from Polk County with the schedules set forth in this rule applying.

This rule is intended to implement Iowa Code section 453A.13, subsections 3 and 4.

701—82.3(453A) Bond requirements. The amount of the bond required for each permit shall be as follows:

1. Distributor permit - $2,500
2. Wholesaler permit - $2,500
3. Vendor permit - $1,000
4. Railway car retail permit - $500
5. Manufacturer permit - $5,000
6. Distributing agent permit - $2,500
7. Retail permit - $-0-
8. Nonpermittee storing interstate cigarettes - $5,000

If a person is required to obtain more than one type of permit, the bond requirements shall be cumulative and additional bonds or a single bond equal to the total aggregate requirements must be obtained. (See rule 701—81.7(453A) for the required form of the bond.)

This rule is intended to implement Iowa Code sections 453A.14, 453A.17 and 453A.23.

701—82.4(453A) Cigarette tax—attachment—exemption—exclusivity of tax.

82.4(1) *Tax.* See Iowa Code section 453A.6 for the rate of tax imposed on cigarettes.

82.4(2) *Attachment.* The tax is imposed when the cigarettes are received by any person in Iowa for the purpose of making a "first sale" of the cigarettes (as defined in Iowa Code section 453A.1). If the tax is not paid by the person making the first sale, it must be paid by any person into whose possession such cigarettes come until the tax has been paid, the tax to be paid only once. The fact that the tax is eventually paid will not relieve the person's standing prior in the chain of distribution of the sanctions for distributing untaxed cigarettes if the tax should have been paid sooner by said person.

The tax must be added to the selling price of every package of cigarettes so that the ultimate consumer bears the burden of the tax.

82.4(3) *Exemption.* If all of the following conditions are met, the Iowa cigarette tax need not be paid:

a. The cigarettes are imported on or about the person claiming the exemption,

b. The total quantity of cigarettes so imported is equal to or less than 40,

c. The seal of the individual cigarette package has been broken, and

d. The cigarettes are actually used by the person so importing and are not sold or offered for sale.

82.4(4) *Exclusivity of tax.* No other occupation or excise tax may be imposed by any political subdivision of the state. However, this provision does not apply to occupation or excise taxes imposed by the state.

82.4(5) *Sales exempt from tax.* Sales of cigarettes which the state is prohibited from taxing under the Constitution or the laws of the United States or under the Constitution of this state are exempt from the tax. If the sale is exempt from the tax, stamps must not be attached. No refund will be issued for stamps which are attached to cigarette packages which are later sold exempt.

a. Sales to the federal government. Military post exchanges or instrumentalities of the federal government are not required to comply with the provisions of Iowa Code chapter 453A nor pay the tax imposed thereunder. However, individuals who have purchased or obtained cigarettes from a federal instrumentality and come within the jurisdiction of the state, are subject to the provisions of Iowa Code sections 453A.6(2), 453A.36(1) and 453A.37. *U.S. v. Tax Commission of Mississippi,* 421 U.S. 599, 44 L.Ed. 2d 404, 95 S.Ct. 1872 (1975).

b. Sales by or to Indians. Sales by Indians to other Indians of their own tribe on federally recognized Indian reservations or settlements of which they are tribe members are exempt from the tax *(Bryan v. Itasca County,* 426 U.S. 373, 376-77 (1976); *Moe v. Confederated Salish & Kootenai Tribes,* 425 U.S. 463, 475-81 (1976)). The Indians are subject to the permit requirements of Iowa Code chapter 453A. Indians who have purchased or obtained cigarettes from an Indian reservation source and come within the taxing jurisdiction of the state are subject to the provisions of Iowa Code sections 453A.6(2), 453A.36(1) and 453A.37.

This rule is intended to implement Iowa Code section 453A.6 as amended by 1999 Iowa Acts, chapter 151.

The cost provisions of 421B.4 would not prevent the distribution of cigarettes in this example, since 421B.4 is silent with respect to below cost combination sales by manufacturers. The cost of cigarettes which are sold is controlled by section 421B.2. The cigarettes sold under the "buy one" portion of the promotion will have a cost of the lower of the true invoice or the lowest replacement cost. The cigarettes sold under the "get one free" portion of the promotion and which were obtained free of charge will have no invoice cost to the retailer.

b. Promotions using noncigarette items. A manufacturer wants to give away promotional items with the purchase of cigarettes at the regular price. Since Iowa Code section 421B.4 is silent with respect to below cost combination sales by manufacturers, the practice of the manufacturer providing a gift item such as cigarette lighters through wholesale channels to retailers which will be delivered to the customer at the time of the sale of the cigarettes does not violate chapter 421B. (See 1958 O.A.G. #22.)

c. Coupons. A manufacturer distributes coupons to the general public to allow the purchase of cigarettes at a reduced price. Provided it is the manufacturer who absorbs the entire cost of the reduction in price, there would be no violation of Iowa Code chapter 421B. Coupons which are sent to the final consumer to be redeemed by a retailer who is reimbursed by a manufacturer do not violate chapter 421B. (See 1968 O.A.G. #68.) This would be true even though the coupon represented the full price of the cigarettes.

d. Replacement packages. A manufacturer wants to respond to a customer complaint by replacing a package of 20 cigarettes purchased by the customer with another package of 20 cigarettes. The replacement package must be clearly marked with the following information:

COMPLIMENTARY. NOT FOR SALE. ALL APPLICABLE STATE TAXES PAID.

The manufacturer may pay the tax directly to the department by submitting an affidavit to the department containing the number of replacement packages sent into the state during the previous month, along with the remittance. The number of replacement packages and remittance may be submitted as part of the manufacturer's affidavit required under Iowa Code section 453A.39 (manufacturer's samples).

This rule is intended to implement Iowa Code sections 453A.1, 453A.13, 453A.16, 453A.22, 453A.31, 453A.39 and chapter 421B.

701—82.11(453A) Refund of tax—unused and destroyed stamps.

82.11(1) *Refunds of unused stamps and destroyed stamps.* Refunds shall be issued for unused stamps which are returned to the department for any reason by a person entitled to receive a refund. This includes unused stamps unaffixed at the close of the business day next preceding the effective date of a decrease in the tax rate which are in excess of the unstamped cigarette inventory on hand as of that date. Banks which are authorized to sell stamps or meter settings are not authorized to issue a refund; the stamps must be returned to and a refund will be issued only by the department. This subrule would also cover stamps which are recalled by the director for purposes of effectuating a change of design of the stamps. A refund will also be issued for stamps which have been lost through destruction, since destroyed stamps have not been used. A refund will not be issued for stamps which are lost (misplaced) or stolen, it being the distributor's or manufacturer's responsibility to maintain proper control over cigarette tax stamps. The claim for refund must be supported by proof of the fact of the loss and proof of the quantity of the loss. The claim must be filed within 30 days of the loss.

82.11(2) *Return of used stamps.* Refunds shall be issued for stamps which have been affixed to cigarettes which have become unfit for use or consumption or unsaleable. This refund is available to any licensed distributor or manufacturer upon proof that the cigarettes were returned to the person who manufactured the cigarettes. The proof required shall be an affidavit from the distributor setting forth to whom the cigarettes were returned and verifying that cigarette stamps had been affixed thereto. There must also be included therewith an affidavit from the manufacturer to whom the cigarettes were returned verifying the information.

82.11(3) *Cigarettes which have been destroyed.* The tax shall be returned on cigarettes which have been destroyed after the tax stamps have been affixed, to the person stamping the cigarettes. The person claiming the loss must be able to prove the fact of the loss and quantity of the loss. The claim, accompanied by proof of the loss and proof of the quantity of the loss, must be filed with the department no later than 30 days following the date the loss occurred. The amount of the refund shall be the face value of the stamps less the applicable discount allowed purchasers of tax stamps. This provision does not apply to cigarettes which are lost (misplaced) or stolen.

82.11(4) *Credit in lieu of a refund.* There are no statutory provisions to allow a credit in lieu of a refund of taxes paid for returned or destroyed cigarette stamps.

This rule is intended to implement Iowa Code section 453A.8.

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SECRETARY OF STATE[721]

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j. Withdrawal notices by candidates filed under Iowa Code chapters 43, 44, 50.46 and 277.

k. Abstracts of votes filed with the state commissioner of elections pursuant to Iowa Code section 50.46.

21.2(2) *Original documents.* The original copy of documents submitted by facsimile machine shall also be filed. The original shall be mailed to the appropriate commissioner. The envelope bearing the original document shall be postmarked not later than the last day to file the document.

a. The filing shall be void if the original of a document filed by facsimile machine is not received within seven days after the filing deadline for the original document.

b. The filing shall be void if the postmark on the envelope containing the original document is later than the filing deadline date.

c. If a filing is voided because the original of a document submitted by facsimile machine was postmarked too late or arrives too late, the person who filed the document shall be notified immediately in writing.

21.2(3) *Documents not acceptable by facsimile.* Only the original of the following documents will be accepted for filing:

a. Absentee ballots and any affidavit required to accompany an absentee ballot under Iowa Code chapter 53.

b. Abstracts of votes filed with the state commissioner of elections pursuant to Iowa Code chapters 43 and 50, except those filed under Iowa Code section 50.46.

c. Nomination petitions filed under Iowa Code chapters 43, 45, 161A, 277, 280A, and 376.

This rule implements Iowa Code sections 43.6, 43.11, 43.16, 43.19, 43.21, 43.23, 43.24, 43.54, 43.56, 43.60, 43.67, 43.76, 43.78, 43.80, 43.88, 43.115, 43.116, 44.3, 44.4, 44.9, 44.16, 45.3, 45.4, 46.20, 47.1, 47.2, 50.30, 50.31, 50.32, 50.33, 50.46, 50.48, 53.2, 53.8, 53.11, 53.17, 53.21, 53.22, 53.40, 53.45, 54.5, 61.3, 62.5, 69.4, 161A.5, 260C.15, 277.4, 277.5, 376.4, 376.10, 376.11, and 420.130.

721—21.3(49) Voter identification documents.

21.3(1) A precinct election official may require identification from any person whom the official does not know.

21.3(2) Precinct election officials shall require identification under the following circumstances:

a. From any person offering to vote whose name does not appear on the election register as an active voter.

b. From any person offering to vote whose name is not on the election register and who wants to report a change of address from one precinct to another within the same county.

21.3(3) The identification document must currently be valid and must show a color photograph and the signature of the cardholder. Acceptable forms include:

a. Driver's license.

b. Nonoperator's identification card issued by driver services division of the department of transportation.

c. Student identification card.

d. A person who does not possess any of the identification documents required by this subrule may fulfill the requirement by having another registered voter of the county who possesses the required identification documents attest to the person's identity. Form 1-S shall be used. The form shall be filed in person by both parties. It may be filed at the polls on election day or at the office of the commissioner at any time before the special precinct board convenes to examine the qualifications of voters who cast special ballots. If the form is filed at the polls on election day, the precinct election officials may permit the voter without identification to vote without casting a special ballot.

21.3(4) A person who has been requested to provide identification and does not provide it shall vote only by special ballot pursuant to Iowa Code section 49.81.

This rule is intended to implement Iowa Code section 49.77(3).

721—21.4(49) Changes of address at the polls. An Iowa voter who has moved from one precinct to another in the county where the person is registered to vote may report a change of address at the polls on election day.

21.4(1) To qualify to vote in the election being held that day the voter shall:

a. Go to the polling place for the precinct where the voter lives on election day.

b. Complete a registration by mail form showing the person's current address in the precinct.

c. Present proof of identity as required by rule 21.3(49).

21.4(2) The officials shall require a person who is reporting a change of address at the polls to cast a special ballot if the person's registration in the county cannot be verified. Registration may be verified by:

a. Telephoning the office of the county commissioner of elections, or

b. Consulting a printed list of all registered voters who are qualified to vote in the county for the election being held that day, or

c. Consulting the county's voter registration records by use of a computer.

This rule is intended to implement Iowa Code section 49.77(3).

721—21.5(47) Election filing deadlines. Rescinded IAB 9/10/97, effective 10/15/97.

721—21.6(49) Ballot boxes. Rescinded IAB 9/10/97, effective 10/15/97.

721—21.7(49) Secrecy folders. Rescinded IAB 9/10/97, effective 10/15/97.

721—21.8(78GA,HF2330) "Vote here" signs.

1. Size. The signs shall be no smaller than 16 inches by 24 inches.

2. Exceptions. If a driveway leads away from the entrance to the voting area, or if the driveway is located in such a way that posting a "vote here" sign at the driveway entrance would not help potential voters find the voting area, no "vote here" sign shall be posted at the entrance to that driveway.

This rule is intended to implement Iowa Code section 49.21 as amended by 2000 Iowa Acts, House File 2330.

721—21.9 Reserved.

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